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VOL. I.—4TH YEAR. SYDNEY: SATURDAY, APRIL 28, 1917. No. 17.

WAR SURGERY AT THE FRONT.

By C. MacLaurin, M.B., M.S. (Edin.),
Lieutenant-Colonel, Army Medical Corps, Australian Imperial Force.

II.

The Treatment of Wounds.

In recounting our various experiences on my return, I happened to mention to an eminent surgeon, who had had very great experience in the early part of the war, that I only saw four or five serious cases of gas gangrene all the time I was in France, and he was so astonished as almost to be incredulous. I know of no better way to express the remarkable change that has come over the surgery of wounds during the last twelve months. This change is due to the perseverance and genius of one man—Lorrain Smith, of Edinburgh, the discoverer of eusol, by which hypochlorous acid, one of the most powerful known antiseptics, can be freely applied to destroy organisms in the presence of living tissues. Eusol is in a way an eponymous word; its individual letters mean Edinburgh University Solution, just as the name of its solid form—eupad—means Edinburgh University Pathological Department. We owe a great deal to the Scottish nation in this war, and not the least of our debts is eusol. Whether there will be any more Scottish nation after the war is a matter for mournful surmise, so terrible has been the destruction among that people. I visited Edinburgh at the end of 1915, and found them much impressed with the remarkable results obtained by the new antiseptic. I brought some of it down to Wandsworth, and succeeded in inducing some of the surgeons there to give it a trial, and in their hands the results were so excellent that it rapidly supplanted all other antiseptics in the treatment of septic wounds. It spread like wildfire over France, and by the end of the spring of 1916 it was almost the only antiseptic used at the front.

At our Casualty Clearing Station most of our casualties were due to shell-fire. It is impossible to conceive and difficult to describe the horror of some of these wounds. It was rare to see any man with only one wound; in most cases, at least those which came under my care, there were many wounds, sometimes amounting to scores if one counted trifling skin punctures caused by flying fragments of mud; it was quite common to see men with eight or ten serious wounds, with immense laceration and destruction of tissues, and often several extremely grave compound fractures and profound hæmorrhage. In these cases, of course, the shock was very great; men would come in, half a dozen at a time, pale, pulseless, and almost unconscious, their bandages soaked with blood, tourniquets on two or three limbs, splints everywhere, and in an appalling state of collapse. The wounds varied from simple through-and-through punctures to the most dreadful laceration and destruction of soft and hard tissues; sometimes a bone would be shattered to small fragments for a great part of its length; arms and legs, feet and hands would hang on by threads; and not the least dreadful of the sights was one that once staggered us, when a long Liston had slipped round and a man was brought in with his foot turned back to front. We felt it our duty to report this case to the Director of Medical Services, and very rightly the long Liston splint was prohibited from that time forth. Of all splints this is one of the worst, and it should nowadays never be used for any purpose.

On opening up a wound one found it packed full of black, oozy mud and fragments of clothing; very often the unhappy patients were crawling with lice, which wandered in horrible proximity to the edges of the destroyed area. Sometimes on removing a packing of gauze a great gush of blood would burst forth, pointing to hæmorrhage only temporarily arrested. The tremendous impact of the projectile had utterly pulped and destroyed all muscle tissue, which crumbled between the fingers like rotten meat; and the X-ray photograph often showed fragments of metal deep in the recesses of the wound. Sometimes bubbles of gas would be shown in the radiogram, or would well up with the blood, showing that already dangerous infection had occurred; and often it seemed hopeless and impossible that even life, let alone limb, might be saved.

It is clear that in such circumstances all the conditions were present for the most deadly infection. A roughly pencilled "T" on the man's forehead showed that anti-tetanic serum had been administered at the dressing-station, so that we could count him fairly free from the danger of that terrible scourge of armies; he had yet to run the gauntlet of hæmorrhage on the table, sepsis, and gas gangrene.

We were very fortunate that our experience of gas gangrene was so small, as nothing like 1% of our patients was attacked by it. I am perfectly sure that this was due to our extensive use of eusol and to the thorough way in which all our surgeons followed the rule of ruthless excision. Other hospitals in the district were less lucky; their technique differed from ours. We differentiated two forms of gas gangrene. A more minute classification has been made, but we came to the conclusion that ours was enough for all practical purposes. We divided gas infection into two forms—a mild and a severe.

The mild form is not uncommon, even now. At the end of 24 hours the skin around the wound would become swollen and discoloured, very much as though it had been painted with iodine, while the patient's pulse-rate and temperature would rise slightly. The swelling would run rapidly up the limb; a distinct sense of crackling would become

obvious to the palpating finger, and the discharge from the would take on a heavy smell. The treatment of this was simply to make free incisions into the subcutaneous tissues, which were always found swollen and water-logged and blueish in tint; recovery was always rapid, and we never saw any of these patients come to any great harm.

The severe form is one of the most terrible and hopeless of human affections. A few hours after the infliction of the wound the patient would become sick at stomach and would vomit; drowsiness, stupor, unconsciousness and coma would appear in their order. The pulse-rate and temperature would rise rapidly, the former rapidly becoming uncountable, the wound would stink, and death would occur that night. In one case the first symptom was a sudden and desperate collapse at four in the morning; by eight o'clock the patient was dead.

It is now known that this is a disease of muscles, and that theoretically one ought to excise all those muscles which are affected; but I am bound to say that I saw no case in which it would have been possible to do anything of an operative nature. The patients were in a hopeless condition as soon as the first symptom appeared.

The routine treatment of our wounds was as follows: The patients were washed and their clothes changed in the ward, usually by the Sister, unless she was utterly overwhelmed by work. *En passant* I should here say that to be a Sister at a Casualty Clearing Station demands extraordinary strength and resolution, and that only large and powerful women can stand the strain. Small women may have the will power and courage, but they simply have not the physical strength, and they should never be sent to the front. The skin around the wound was shaved and painted with iodine in the usual way, and the gauze packing cautiously removed from the wound. We found that the ordinary swabs and strips of gauze used in civil practice were rather small for Casualty Clearing Station work, owing to the gigantic size of many of the wounds; when a gush of blood occurred it was often necessary to seize a whole double handful of swabs and dash them into the wound instantly. For this reason, and as there is practically no refined and delicate surgery at a Casualty Clearing Station, I should recommend that all swabs and strips for these hospitals be made considerably larger than usual.

The damaged skin around the wound was rapidly cut away with scissors, and the depths explored. Any large vessels seen were caught; the wound swilled out with eusol and all foreign matter removed as thoroughly as possible. We regarded it as of the utmost importance to cut away all pulped muscle. This tissue would never recover, and if left behind would only form a nidus for organisms, so we invariably cut it away till healthy bleeding muscle-tissue was reached. We used to spend a great deal of time over this work, and never felt satisfied unless we left a red and raw surface, free from obvious dirt. Hæmorrhage then had to be finally arrested, and it was never safe to leave a wound unless hæmostasis was perfect.

In the case of perforating wounds, which are notorious for their liability to gas infection, we used to pass a strip of gauze from side to side, thoroughly soaked with eusol, and scrub the inner surface of the wound with energy, using fresh eusol-soaked gauze until we were satisfied that all the damaged tissue had been removed.

The question of drainage was solved by Alexis Carrel, the great French-American surgeon, whose devotion to his motherland has led him to establish a small but perfectly equipped base hospital for her soldiers. The problem was to secure the constant application of fresh eusol to the surface of the wound, which would get rid of septic discharge by not allowing any to be formed. Carrel did away entirely with dependent drainage, and that is the whole secret of his method. If there is dependent drainage the eusol simply runs out as soon as you put it in, and the bacteria can work in peace, and even perhaps acquire a certain immunity to hypochlorous acid; but, according to Carrel, if the lower exit of the wound is firmly closed, then the whole wound is constantly bathed with fresh eusol, and rapidly becomes aseptic. The devising of this simple method has saved thousands of lives.

Carrel, after thoroughly cleansing the wound, first packs the wound of exit firmly; he then leads into the depths of the wound several small tubes, smaller than a lead-pencil, with the sides perforated with numerous small holes; around these tubes are loosely packed long strips of gauze, which are kept wet with eusol by pouring the solution into the tubes every two hours. Over the patient's bed is hung an ordinary douche-can with a tap; the tube from this is led to a small glass tube with two, three, or more little glass tubes leading from it, to the ends of which are fitted the ends of the rubber tubes leading into the wound. The nurse makes her round every two hours, and as she passes each patient she turns on the tap for a minute or two, so that eusol runs into the tubes, soaks the gauze and keeps the whole wound full of fresh solution. At the end of twenty-four hours the whole dressing is changed under anæsthesia, but after that the daily dressing is, or should be, almost painless, and can be done without anæsthetic.

I have no hesitation in saying that this method is far superior to the use of hypertonic salt solution, at any rate at the front. It is more trouble to the surgeons and nurses; but the results are better in the experience of everyone with whom I conversed during my stay in France. Moreover, the consulting surgeons were unanimous in the same opinion, and they had the advantage of seeing the work at all the clearing stations.

For simple perforating wounds, which would have been difficult to treat by the "Carrel-eusol" method, we used to pass a tube of gauze from side to side and pack this full of salt tablets, leaving it *in situ* as a rule until the patient was evacuated in a day or two. As far as I know, the results by this method were uniformly good, if adequate cleansing of the wound had been done in the first instance.

Similar treatment was applied to large superficial wounds with little or no deep destruction of tissues;

these wounds used to heal up splendidly under the salt pack. Where the method failed was in the huge, deep, lacerated wounds, with immense destruction of tissue, and it was in these cases that the "Carrel" treatment was such a God-send.

Fractures were, of course, too numerous to mention; nearly every man who came into the "serious ward" had one or more of these injuries. We treated them by Carrel's method, eusol and Thomas's knee or elbow splints. We tried many splints, but came ultimately to the conclusion that for the leg the Thomas's knee splint was applicable from the great trochanter to the ankle, and for the arm his elbow splint suited perfectly well for every fracture below the shoulder. For the ankle Jones's "crab-splint" is the best. With these three splints I think one would be perfectly safe in treating almost every fracture, both in military and civil life, and they have the great advantage that they favour ease of transport.

The question of fractures naturally leads to that of amputations. When is one to try to save a limb? When to amputate? Since the advent of the "Carrel" treatment surgeons are not so ruthless, because we know that gas gangrene is less likely to ensue than formerly; yet, even now, it is unwise to run too great a risk. Possibly the old rule, that amputation is necessary when no pulse can be felt at the wrist or ankle, is still good; and certainly it was the rule that we followed. Whenever we could feel a distinct pulse we did not hesitate to make an effort to save the limb; and we were fortified in our efforts by the knowledge of the remarkable progress which has recently been made in bone-grafting.

Indeed, one might almost say that the whole question of urgent bone surgery is still fluid. Opinion is still divided as to whether it is necessary to remove shattered fragments of bone, or whether the wisest thing is to remove the injured fragments, and simply to leave the large pieces that are practically certain to live. Our own solution of the difficulty was, after getting the wound thoroughly clean, to inspect all the shattered fragments, and to remove only those which were obviously quite loose. Whenever a fragment was still attached to periosteum, and had a chance of survival, we left it alone, and as far as we could tell with successful results. But this rule would not necessarily be followed unless the "Carrel-eusol" method were to be followed out with strictness, because there is no doubt that even when bone is still attached to living periosteum, severe inflammation can kill it as though it had been entirely stripped, and such fragments will not then live; but as the "Carrel-eusol" treatment, when properly carried out, usually minimizes subsequent inflammation, it is safe to make a more vigorous effort to save fragments than would otherwise be the case. It is, however, proper to remove large amounts of dead and moribund bony fragments, in the expectation that at a later date it will be possible to replace even enormous gaps by bone-grafting. The experience of great numbers of surgeons at home hospitals in England is that this latter operation should never be resorted to until at least six months after the original wound has healed, and only then if the radiogram shows the separated ends of the bone to be in a healthy condition and free from any sign of rarification.

The treatment of shattered limbs may be summed up as follows: When there are facilities for strict asepsis, efforts may be made to save almost every fragment; in the comparative absence of these facilities it is better to remove all the fragments, unless they are practically certain to live. Amputation should not be resorted to merely for bone injuries, even if the whole bone be shattered, but only if the pulse has entirely disappeared at the wrist or ankle.

The guillotine amputation is thoroughly bad, and is not to be used except in severe cases of gas gangrene, when nothing much matters. It is better to fashion ample flaps in the ordinary way, and to leave them open, kept apart by gauze treated according to Carrel's method. These stumps always, so far as I know, reached the base in a beautifully clean condition.

CÆSAREAN SECTION IN INFECTIVE CASES AND THE VALUE OF ADEQUATE DRAINAGE.[1]

By **W. A. Verco, M.B., B.S. (Adelaide),**
Gynæcologist, Adelaide Hospital.

It is asserted in obstetric and gynæcological textbooks that if there is any risk of infection having taken place in the pregnant uterus the operation of Cæsarean section should not be performed, on account of the probable supervention of an acute infection of the peritoneal cavity and the early death of the prospective mother. In place of Cæsarean section, embryotomy, symphysiotomy, or pubiotomy are recommended. The first operation is destructive to the fœtus, and is also attended with a very distinct risk to the mother. The latter operations both have their risks and disadvantages, though they may be the means of saving the life of the baby. Other recommendations are: (1) Eventration of the uterus through a large abdominal incision and the partial closure and shutting off of the peritoneal cavity by towels and clips while the uterus is being opened and closed. (2) Transperitoneal Cæsarean section, with closure of the general peritoneal cavity, by uniting the parietal and visceral layers of the peritoneum together. (3) Extra-peritoneal Cæsarean section through the space of Retzius: the separation of the bladder from the lower uterine segment, opening the uterus through this segment, extracting fœtus and after-birth, sewing the uterus up, and replacing the bladder over the incision. But with all these attempted refinements, the disabilities and risks remain. Peritonitis still occurs; fatal suppuration in the connective tissue planes eventuates; sloughing of peritoneum happens; and the death-rate has not been appreciably diminished. In addition there is the great disadvantage and the increased difficulties and dangers that have to be encountered through operating in a confined space. Another proposal is to eventrate the uterus, remove the fœtus and after-birth through an opening on the

[1] Read at a Meeting of the South Australian Branch of the British Medical Association on February 22, 1917.

posterior surface of the uterus, and, after sewing it up, to drain the pelvic cavity through the posterior *cul-de-sac*. This proposal need only be mentioned to be condemned for many reasons.

In thinking over this class of infective cases and the treatment advised in the text-books to meet the emergencies, it seemed to me that full advantage had not been taken of the more complete knowledge of the surgery of the peritoneal cavity. We are aware that the peritoneum can overcome a limited infection by harmful germs, especially if not very virulent; but as we are never sure of the exact amount of the infection or the intensity of the virulence in any case it is better and safer surgery, when we are in doubt, to provide drainage for the escape of the germ-laden fluid and exudate, rather than to shut it in a large and very absorbent cavity, whence there is no immediate outlet. So, it seemed to me, that in these infective parturient cases, the Cæsarean section, with certain modifications, could still be fairly safely performed, if there were only provided a means of escape for the germs and germ-laden fluid that may have gained entrance into the peritoneal cavity during the extraction of the fœtus and afterbirth from the uterus, or that may have been introduced through seepage occurring afterwards through the uterine wound.

Some three years ago three patients who had been subjected to Cæsarean section died at the Adelaide Hospital within a short time of each other. It seemed to me that they ought not to have been lost, and I felt fairly certain, on consideration of the different cases, that if provision had been made for drainage the patients would not have succumbed.

In doing Cæsarean section in these cases it is advisable, instead of the classical high abdominal incision, with incision through the fundus, to make a subumbilical incision, with the uterine incision low down on the anterior surface. In this manner one would have the infective matter located, as far as possible, in the lower peritoneum. Large protective mops would be packed carefully around the proposed uterine opening before making the incision. After the womb had been sewn up in layers, a rubber drain, or two rubber drains, would be inserted in the lower angle of the abdominal wound, with iodoform gauze wicks. The gauze would be removed in 24 to 48 hours, and the tubes a little later. There is certainly a risk of a weak spot in the lower portion of the abdominal scar, and the subsequent development of a hernia, but this should not influence us when the mother's life is at stake. The safety of the mother should always be our first consideration.

I will now briefly enumerate six cases of Cæsarean section that have been performed under distinctly unfavourable conditions, and that, according to the axioms of most text-books, should not have been done.

(1) Mrs. H. came into the Adelaide Hospital in the evening. Four different doctors, on two separate occasions, had endeavoured to deliver the baby. It was a L.O.A. presentation. There was a decided disproportion between the size of the fœtus and the pelvis of the mother. The baby was probably one month past term. The mother looked decidedly ill, and her pulse-rate was 160. On opening the uterus a dead fœtus was extracted, and a fishy-smelling after-birth was removed. The inner uterine surface had a peculiar yellowish coating on it. As the uterus had a very definite infection, and was much bruised, a supravaginal hysterectomy (Porro's Cæsarean section) was performed. A rubber and wick drain was inserted through the lower angle of the wound. A distinct peritonitis developed, and there was a foul-smelling discharge from the wound for a while; but she made a good recovery.

(2) A case of inoperable cancer of the cervix, with a malodorus discharge, sent from the country. She was six months pregnant. As she could not remain in the city until pregnancy was further advanced, a Cæsarean section was performed. The uterus was sewn up in layers, a rubber and wick drain inserted in the lower angle of the abdominal wound. The patient developed a local peritonitis, and there was a foul-smelling discharge from the wound for a few days. She made an excellent recovery.

(3) A primipara at term had been in labour for 36 hours. A foot was protruding from a vulval outlet. Extraction, by dragging on the foot and leg, had been attempted at the Salvation Army Home. There was prolapse of the funis, and the child was dead. The leg was amputated and the prolapsed cord was excised. The vagina was then irrigated with an antiseptic lotion. The abdomen and uterus were opened and the child and placenta were removed. The uterus was sewn up in layers and a rubber wick drain inserted through the lower part of the wound. There developed quite an evident peritonitis, with marked distension. There was an evil-smelling discharge from the drain, as in the other cases. She gradually became quite well again. The obstruction was due to the narrowing of the pelvic outlet to about 2½ inches in the transverse diameter, caused by old bone disease in the sacro-iliac region.

(4) A primipara, æt. 22 years, had been in labour for 24 hours. Delivery had been attempted in the morning by means of forceps at her home, and again in the evening at the Adelaide Hospital. An operation was carried out at 8 p.m. The head had presented, but had not engaged at the brim, on account of the undue prominence of the sacral promintory, thus lessening the true conjugate. After extraction of the child and placenta through the low uterine incision, a rubber and wick drain was inserted. There was slight distension afterwards, and a *bacillus coli communis* smelling discharge from the drain. She made a good recovery.

(5) A primipara, who had been in labour for 24 hours, was sent to me by Dr. Drummond. The uterus was lying diagonally, with the head in the right iliac region and breech in left hypochondriac region. Behind the head in the pelvis was a fairly large ovarian cyst. Under ether anæsthesia an endeavour was made to push the cyst up out of the way, with a view to forceps extraction, but it could not be moved. The abdomen was opened, and it was then found that there were two uteri, the left one being pregnant. To the right uterus was attached the ovarian cyst, which was firmly fixed in the pelvis. The pregnant uterus was opened, the

baby and placenta removed, the uterus sewn up in layers. The uterus was then eventrated, and the ovarian cyst was found fixed between the layers of the broad ligament and to the rectum. In separating it the cyst broke, and was found to have a very distinct *bacillus coli communis* infection. Two rubber and wick drains were inserted into the cavity from which the cyst had been removed and brought out at the lower angle of the wound. There was a stinking discharge for three weeks. Both mother and baby did well.

(6) A woman, 5-para, had been 18 hours in labour. There had been no pregnancy for eleven years. The four infants had been delivered by means of forceps, the first and fourth deliveries having been very difficult. In this case there was a head presentation—occiput anterior. The sacral promintory was very advanced, reducing the conjugate to three inches. The head had not engaged. Delivery was attempted at the home by two medical men with forceps under anæsthesia. The abdomen and uterus were opened by the low incision. The after-birth presented; it was separated and delivered with the fœtus. The baby was alive and head was much marked by the blades of the forceps. A rubber and gauze drain was inserted. There was general distension, and after a few days the usual foul-smelling discharge. Both mother and baby made a good recovery.

These six cases illustrate the value in infective cases of Cæsarean section of (1) the low abdominal and uterine incision, and (2) of well devised drainage of the lower peritoneum. If it had not been for the drainage, the probability is that all these six mothers would have succumbed within a few days to peritonitis.

Reports of Cases.

A CASE OF POISONING BY HYDROCYANIC ACID GAS.

By **A. M. McIntosh, B.A., M.B., Ch.M. (Syd.),**
Brisbane.

Poisoning by inhalation of hydrocyanic acid gas appears to be a comparatively rare occurrence in Australia. Dr. Corlette[1] was able to find record of only two fatal accidents of this nature; one other in Brisbane escaped his observation, and the present constitutes the fourth. In the circumstances, the notes of this case seem to present sufficient interest to merit publication.

Some rooms in Brisbane were in course of fumigation by cyanide gas under the supervision of a trained chemist, who had had considerable experience of this work. The accident occurred in connexion with the treatment of a small room of 1,300 cubic feet capacity. The quantities of chemicals used were:—

Potassium Cyanide	24 ozs.
Sulphuric Acid	24 fluid ozs.
Water	48 fluid ozs.

The method adopted in this particular case was not one that would commend itself to men experienced in the use of hydrocyanic acid gas for disinfection purposes. The cyanide was first placed in a dish, the water and sulphuric acid mixed, and the mixture then poured on to the cyanide. The room had previously been sealed, with the exception of one door for exit, and the addition of the fluid to the cyanide caused a great evolution of gas, with the result that the operator inhaled sufficient of it to make him dizzy. He immediately dashed from the room, and called to his assistant to close the door and seal it up. Assistance was summoned, and, on arrival, it was found that the former had quite recovered from the effects of his inhalation; but when the room was visited the assistant was seen lying on the floor unconscious, with his head near the dish containing the cyanide. This was about three minutes after the officer had left the room. He was quite unconscious, his breathing had stopped, his pulse could not be felt, and he had lost his corneal reflex. He was hurriedly pulled out of the room, and carried into the open air. With artificial respiration he began to breathe, at first slowly; oxygen was administered, and strychnine sulphate, gr. $^1/_{30}$, hypodermically. When he was discovered his face was very pale, later it became more pink than normal; his breathing, at first six to the minute, gradually increased to normal, and was very stertorous in character. His pulse gradually became stronger, and his corneal reflex returned. A pinkish, frothy mucus collected in his mouth, and necessitated the constant cleaning out of his throat for some two hours after he was found. At this time he was given a hypodermic injection of atropine sulphate (gr. $^1/_{100}$), with the result that the exudation was greatly checked. His temperature was now about normal, his face slightly flushed, and his respiration continued laboured and stertorous; all his limbs were flaccid, his urine and fæces were passed involuntarily, and his pupil re-acted sluggishly to light. Later in the afternoon he began to have general convulsive seizures, closely resembling those of tetanus, with a typical *risus sardonicus*. These seizures lasted about five minutes, and recurred at intervals of ten minutes. He was given two injections of morphine, ¼ gr. in all. This somewhat diminished the violence and frequency of the convulsive seizures. Next morning he could swallow a little, and was given brandy and water at intervals. He was still passing urine in the bed. On this day the spasms were much less frequent and severe. Lumbar puncture was performed, 14 c.cm. being withdrawn under slightly increased pressure. The fluid showed no departure from normal. At this time 20 c.cm. of hydrogen peroxide were injected subcutaneously. It was noted that the Babinski reflex was positive on both sides. His knee-jerks were very sluggish; there was no ankle clonus. Towards evening his breathing became more and more stertorous, and he was very restless during the night, moaning off and on; the spasms also occurred with greater frequency. His urine was examined and found to contain a considerable amount of pus, but there was no trace of any hydrocyanic acid nor any other abnormality.

On the succeeding days there was little change in his nervous symptoms. The spasms recurred with less frequency as time went on, and also diminished in severity; during the spasms he moaned as if in pain. His temperature gradually rose; his heart was normal throughout. No abnormality was noticed in his lungs, except a short time before his death, when there were some moist sounds at the bases.

On the evening of the 5th March his pulse became much weaker and softer, and he died the following morning at 5 o'clock, 110 hours after inhalation of gas. His temperature rose to 106° a few hours before his death.

A post-mortem examination was carried out, and the only abnormality found was a slight congestion of the cerebral convolutions, and a well-marked pyelitis, this latter being due to a long-standing gonorrhœal infection. The whole of the brain was very carefully examined, but no abnormality was apparent to the naked eye. Some of the blood obtained at the post-mortem examination was submitted to the Government Analyst, who was, however, unable to find the slightest trace of hydrocyanic acid, or any of its compounds.

The mode of action of this poison has apparently not

yet been definitely decided; these notes may perhaps throw some light on the problem.

I am indebted to Captain V. N. B. Willis, Australian Army Medical Corps, for the clinical notes of this case.

Reference.

[1] C. E. Corlette, "Insecticidal Fumigation in Ships, with Special Reference to the use of Hydrocyanic Acid," *The Medical Journal of Australia*, November 4, 1916.

Reviews.

OPERATIVE GYNÆCOLOGY.

A wide choice of operations, a methodical and detailed account of technique, and a wealth of admirable illustrations characterize Dr. Crossen's work "Operative Gynecology."[1] In his preface the author is at some pains to point out that the present stage of gynæcological surgery involves, more than previously, the adaptation of operative measures to the exact pathological conditions present in the individual patient, and so far as it is possible with our present state of knowledge, to make the adaptation a precise one, it will be admitted that Dr. Crossen has achieved a notable success. While the experienced gynæcological surgeon may question the necessity for some twenty differing technical procedures for the cure of retrodisplacements of the uterus, each of which is well described and illustrated, the less experienced will find in a study of these methods the underlying principles of Dr. Crossen's gynæcological philosophy, and be enabled to make a valuable and satisfactory application thereof to special cases. Some idea of the fullness with which the author deals with his subject will be gathered from the fact that retro-displacements and prolapse of the uterus take up 125 pages. The chapter on pelvic floor relaxation and fistulæ is, from the standpoints of descriptive and technique, a model of clarity and precision, and represents as convincingly as may be the most practical way of dealing with injuries to the pelvic floor.

In discussing fibro-myoma of the uterus, Dr. Crossen does not support any particular theory of treatment. He devotes a dozen pages to the question of the indications for operative treatment, and his conclusions, which he says are working rules for the present, do not favour operation for a small fibroid "that is causing no symptoms," or for a tumour of a moderate size, causing only slightly troublesome symptoms, which may yield to general tonic treatment with the addition of uterine astringents, *e.g.*, ergotin, stypticin, etc. Before recommending operation he apparently waits till "the tumour itself is already a continual irritant in the pelvis." One must confess that after the elaborate summary which precedes these working rules, the conclusions are somewhat unconvincing and disappointing; such influencing factors as age, married or unmarried state, relation to childbirth, do not seem to have been given their place in considering the verdict. But here again Dr. Crossen states frankly that he has an open mind, and welcomes any information establishing the safety of waiting in these cases.

The subject of malignant disease of the uterus is dealt with on up-to-date lines, the radical operation is well described and illustrated, and while not favouring the attempt at complete systematic removal of the pelvic lymphatic glands, he considers it practical and advisable in certain cases, to remove one or more groups of enlarged glands, especially those of the hypogastric group. In these days of "too-late cases" it is very satisfactory to find Dr. Crossen giving an excellent account of palliative operations.

A very interesting section is that on auto-transplantation and hetero-transplantation, a monograph in itself, which comes at the end of the chapter on conservative surgery of the ovaries and tubes. It embodies the results, among others, of Tuffier's investigations, and draws largely from his historic paper of January, 1915. The treatment of absence of the vagina is discussed in regard to Baldwin's method by transplantation of a loop of intestine and Schubert's operation of resection of the rectum; both methods are well described and illustrated.

Imperfect development of the uterus, with anteflexion, and cervical stenosis receive due consideration; and the use of stems, wholly intra-uterine, is contrasted with the posterior and the bi-lateral division of the cervix in favour of the stem treatment.

The chapter on abdominal section is familiar matter presented in an interesting way; the pitfalls for the unwary are writ large; and the list of reported cases (222) of a foreign body lost in the abdominal cavity, with the detailed account of their genesis and exodus, is a text that supplies its own comment.

The final chapter is devoted to the consideration of medico-legal points; and the final section, an excellent summary by Howard Kelly on the subject of promises to patients, should appeal for its wisdom and candour, alike to the general surgeon and the specialist.

[1] Operative Gynecology, by Harry Sturgeon Crossen, M.D., F.A.C.S., 1915. St. Louis: C. V. Mosby Company. Melbourne: Stirling and Company. Royal 8vo., pp. 670, with 770 illustrations. Price 35s.

University Intelligence.

UNIVERSITY OF WESTERN AUSTRALIA.

A meeting of the Senate of the University of Western Australia was held at the University Buildings on March 20, 1917. Archbishop Riley was elected Chancellor for the ensuing year, and Mr. Cecil Andrews, M.A., was re-elected Pro-Chancellor. The Chancellor welcomed Dr. R. C. E. Atkinson and Professor Murdoch, who had been elected by convocation members of the Senate. The welcome was extended also to Mr. J. S. Battye, a new member of the Senate appointed by his Excellency the Governor.

It was determined to accept with thanks a collection of rocks and minerals offered by Professor Woolnough, and instructions were given to the General Purposes Committee to consider the question of accommodation.

It was resolved that a letter be sent to Dr. Roberta Jull, expressing the Senate's deep sympathy with her in the loss which she had sustained on the death of her husband. It was also resolved that a letter of sympathy be sent to the son of the late Dr. J. W. Smith, a former member of the Senate, and to express the appreciation of the Senate in regard to Dr. Smith's past services in connexion with the University.

It was resolved that a degree ceremony should be held as usual in the year 1917.

The Senate proceeded to appoint the members of the Finance Committee and of the General Purposes Committee. The Chancellor and Pro-Chancellor, Professor Murdoch and Messrs. J. S. Battye, J. P. Colebatch and W. Somerville were elected members of the former, and the Chancellor and Pro-Chancellor, Sir Walter James, Professor Murdoch, Dr. Atkinson, Dr. Jull and Messrs. J. S. Battye, W. J. Hancock and W. Somerville were elected members of the latter.

The following notices of motion were received by the Pro-Chancellor:—

> That the regulations be so amended as to provide that no one shall be admitted to a degree unless he has taken a course in one of the sciences that are included in the curriculum of the University;

and by Sir Walter James:—

> That inasmuch as the University is solely supported by State finances, and as the future success of the University so largely depends upon the public knowledge and appreciation of the work of the University, meetings of the Senate be opened to the press.

It is announced in the *Government Gazette of Western Australia* of April 5, 1917, that his Excellency the Lieutenant-Governor, on the advice of the Executive Council, has extended the regulations under Section 3 of the *Health Act*, 1911-1916, by the inclusion of the disease Anthrax among the "infectious diseases" recognized in the Act.

The Medical Journal of Australia.

SATURDAY, APRIL 28, 1917.

The Call for Men.

We have been asked by the authorities of the Medical Services to appeal to the members of the medical profession throughout the Commonwealth to offer their services for duty with the Australian Imperial Force at once. Every available man is required, and every volunteer who is found suitable will be sent overseas at an early date. Young practitioners are being sought in preference, but we understand that others of maturer age may be accepted. The call is very urgent, and, coming as it does immediately on the conscription of the whole profession in Great Britain, it will appeal forcibly to Australian doctors. It will probably be necessary to deplete the junior staffs of the large general hospitals, and we would suggest to senior practitioners who cannot be usefully employed by the country in any other manner to lay pride aside and take on the young man's job during the time of stress. The Department of Defence will send to France every available medical practitioner within the next two months, and since the response must be a voluntary one, the medical profession will have an opportunity of demonstrating its keenness and loyalty. Too many men cannot apply.

THE TREATMENT OF WOUNDS.

The experience of medical officers who have served the country in casualty clearing stations, and base hospitals, and who have seen the fearful nature of sepsis supervening on wounds received in France, has led to an extraordinary variance as to the relative value of the prevailing modes of dealing with these wounds. In the present issue we publish a highly interesting article written by Dr. Charles MacLaurin, in which he extols the virtues of eusol, and gives praise to the Dakin-Carrel method of applying it. In recent issues other observers have recorded what they have seen and the views they have formed, and from these articles the impression may be gained that the adherents of the open method of treating wounds with irrigations of saline solution have a good case. In last week's issue, Dr. Halford argued on a sound basis that wounds are retarded in their healing by the action of any antiseptic, and that nature's means of repair consists in the agglutination of a divided surface or in the building up of a destroyed area under the protection of a scab. From these publications and from many others in other medical journals, it would appear that the problem in warfare in regard to the treatment of wounds resolves itself into two factors. The first consists in the removal of all foci of sepsis which may endanger the life of the wounded soldier, and the second consists in the furthering of the processes of repair. In civil practice, unless a wound is greatly soiled, the surgeon has but little difficulty in preventing the development of septic infections. Where contamination has occurred, the infection may be overcome in one act by the energetic application of an efficient antiseptic, and it would seem as if Dr. Halford's suggestion to leave the wound rigidly alone after this preliminary disinfection, keeping the natural scab desiccated by the application of alcohol, would satisfy all the requirements of the case. In wounds inflicted by the projectiles of modern warfare, a single preliminary sterilization is impracticable. Every military surgeon agrees that the only chances of limiting the septic process lies in some continuous application. Up to the present, notwithstanding the vast number of wounds that have been treated by disinfection with soduim hypochlorite, by the Dakin-Carrel method, or by Sir Almroth Wright's method, no statistics have been presented from which an objective conclusion concerning their relative values can be drawn. No one will deny the high antiseptic power of the hypochlorites. Similarly no one wishes to question the truth of the contention that even eusol injures tissues and delays physiological repair. In the case of wounds in which infection is lurking in corners and crannies, it may be impossible to compel any antiseptic to effect its action until nature has permitted free access to the remotest nooks of the

wound by the local death of the tissues. It would also seem to be a generally accepted fact that the risk of fatal infection from imprisoned bacteria is largely diminished if the wound be opened up as far as possible and kept open for the purpose of admitting of free exit for all discharges. If there is general agreement on these points, there should not be room for great divergence of opinion in regard to the wisest course to pursue in serious wounds. Unless Sir Almroth Wright's method can be shown to suffice to dispose of the more dangerous forms of wound infection rapidly and with certainty, surely it must be safer to utilize a powerful antiseptic, such as sodium hypochlorite, to the wound for the shortest time compatible with a safe sterilization of the wound. The middle road of the Dakin-Carrel method appears to offer the patient the most favourable chances. The wound is kept freely open, and the deepest recesses that may be infected are reached within a reasonable time by the antiseptic. The primary danger to the wounded man is combated with as little damage to the tissues as is practicable, and as soon as this danger is over, the restraining influence on repair can be withdrawn. On the other hand, the adherents of Sir Almroth Wright's method claim results which are as good as those obtained by eusol. From the enthusiasm with which Dr. Charles MacLaurin and many others speak of eusol, we are inclined to the belief that when an opportunity is offered of comparing similar series of cases treated by the two methods, the verdict will be given to the Dakin-Carrel method.

HYDROCYANIC ACID POISONING.

In the present issue Lieutenant-Colonel McIntosh relates the details of a highly interesting instance of poisoning by hydrocyanic acid gas. While the symptoms, with one exception, were similar to those usually met with in this form of poisoning, the case presents certain peculiarities which may be of use in determining the mechanism of poisoning. In this case a man was exposed to an atmosphere containing an unknown concentration of hydrocyanic acid vapour for a period of about three minutes. His respirations had stopped and he was very pale when found. Notwithstanding the violence of the symptoms, the man recovered from the immediate effects of the vapour, and although he exhibited tetanoid symptoms, with disturbed consciousness, characteristic of the more chronic forms of hydrocyanic acid poisoning, he survived for four and a half days—a length of time which is unusual. The one symptom which, as far as we are aware, has never been described before is the gradual rise of temperature. In hydrocyanic acid poisoning the temperature falls suddenly, and rarely reaches the normal level again before death. The blood was examined after death, but no trace of cyanogen was discovered. Many observations have been carried out in these cases, and it has been determined that the sojourn of hydrocyanic acid in the blood is brief, usually not longer than 24 hours. Later it appears in the tissues as sodium cyanide. Its ultimate fate is difficult to follow; whether it is excreted as a cyanide, combined with an aldehyde or oxidized in the tissues is a matter on which various opinions have been expressed. In a similar manner it is mere conjecture that led Löw, Nef and others to suggest the chemical action within the body on which the toxic effects are based. On the other hand, Geppert demonstrated many years ago that the presence of cyanide in the tissues is followed by an extraordinary reduction in the oxygen intake of the tissues. This reduction of metabolism is obviously induced by an action on the nerve centres, and is not due to a direct action on the tissues themselves. The tissues are prevented from taking up the normal amount of oxygen from the blood, and consequently the output of carbon dioxide is also diminished. A second consequence of this change is the increase in quantity of lactic acid and sugar in the blood. In the more chronic forms, such as existed in the case described by Lieutenant-Colonel McIntosh, the disturbance of the oxygen metabolism becomes less marked as time goes on, but even during the cramps the oxygen content of the tissues is lowered and the carbonic acid content of the blood never reaches the normal. Whether this state of affairs can last for four and a half days cannot be said, since no measurement of the carbonic acid excretion was undertaken. The fact that the heart remained normal throughout the course sug-

gests that it did. The objective result of the diminished intake of oxygen by the tissues and the restriction of the carbonic acid output would be a gradual failure of the respiratory centre, due to the absence of natural carbonic acid stimulation. The fever remains unexplained, unless indeed we can assume that the lowered metabolism induced a reduction of resistance toward the renal affection, and a consequent increased manufacture of bacterial toxins from this focus of infection. The changes discovered after death correspond to those usually met with, although it is not infrequent to find minute hæmorrhages in the brain in chronic cases. At times these hæmorrhages are sparsely distributed over the white matter of the cerebrum and medulla, and may be so minute as to be detectable only under the microscope. It may therefore be stated that the case described offers some confirmation for the theory first elaborated by Geppert, which was based on direct observation, both on human patients and on experiment animals.

THE CONTROL OF VENEREAL DISEASES IN TASMANIA.

The Legislature of Tasmania has followed the example of those of Western Australia and Victoria, and has placed among its Statutes an Act amending the Public Health Act, 1903, by which venereal diseases are brought under control. The text of the amending Act appears elsewhere in the present issue. This Act contains sections culled from both the Acts recently passed into law. The medicinal treatment of those suffering from venereal diseases is restricted to medical practitioners. A simple clause exempts the registered pharmaceutical chemist who dispenses to the patient of a medical man the signed and dated prescription of the medical practitioner from the section dealing with those who may treat such patients. Every person suffering from venereal disease, must obtain advice forthwith from a medical practitioner, or must attend at a hospital or at a place prescribed for the treatment of these diseases. Until a certificate of cure has been received, the patient must attend for treatment once in every four weeks. The medical practitioner consulted by any person suffering from venereal disease, must inform the Chief Medical Officer of the attendance without giving the name or address of the patient. When any patient fails to return for treatment for six weeks, the medical attendant must send to the Chief Health Officer a notice including the name and address of the patient, unless he has been informed by some other medical practitioner that the patient is under treatment. The Chief Health Officer is given power to order the patient to obtain treatment from a medical practitioner. If the patient does not comply with the request of the Chief Health Officer, a police magistrate may by warrant order the patient to be detained for any period not exceeding four weeks in any prescribed place, so that such clinical, chemical, bacteriological and other examinations may be carried out to determine whether the patient is suffering from venereal disease. If the patient is found to be affected with venereal disease, the Governor is given power to order a further period of detention on the report of the Minister that detention is necessary in the interests of the patient or the public welfare. The right of appeal is given to the patient, and this right can be exercised once in every three months. Any person undergoing detention who can satisfy the Minister that he can obtain and is prepared to undergo suitable private medical treatment, may be released from custody. Every person detained in a place set apart for the care of patients suffering from venereal disease, must be examined by two medical men once in every three months. Women have the right to be examined, when practicable, by women medical practitioners. Prisoners under sentence who may be suffering from venereal diseases may be removed to a place set apart for the treatment of these diseases and detained for treatment. Such prisoners may appeal once in three months. The parents and guardians of persons under sixteen years of age must obtain treatment for such persons.

Imprisonment for twelve months is the penalty for infecting knowingly any person with venereal disease. Hospitals lose their subsidy, or portion of it, if they fail to provide for the care and treatment of sufferers from venereal diseases. Power is given to the Minister to establish hospitals and dispensaries for the reception and treatment of patients, to arrange for treatment by medical practitioners or at hospitals not receiving aid from the State, and to arrange for clinical, chemical and bacteriological examinations and investigations free of charge to the patient. The Act follows the Act in force in Western Australia in giving the Chief Health Officer power to act upon the signed statement of any person in which it is asserted that some person is suffering from venereal disease. The Chief Officer may require the person mentioned in the statement, to obtain treatment from a medical practitioner. If the order is not obeyed, a police magistrate may commit the person to a place of detention for the purpose of an examination to determine the presence or absence of venereal disease. A penalty of fifty pounds is provided for furnishing a wilfully false statement to the Chief Health Officer.

PASSIVE IMMUNITY TO TETANUS.

When an individual becomes infected by a pathogenic bacterium certain changes take place within his body, which are of a more or less permanent character. These changes apparently vary according to the form of bacterium and the degree of susceptibility of the individual to the bacterium. After an attack of enteric fever or morbilli the serum acquires properties, which are usually associated with

what are termed antibodies, and which in their summed effect on the body prevent the individual from falling a victim to the disease a second time. No one has ever isolated an antibody, and the evidence of innumerable experimental researches merely goes to prove newly-acquired properties. Whether these properties depend on actual substances, or whether they are the result of some subtle change in the molecular arrangement of normal blood constituents could only be demonstrated after an investigation into the chemico-physical nature of antibodies. Other bacteria produce changes of the same nature, but the resulting effect on the individual is quite different. Once the infection is conquered the individual regains his power to acquire the disease as before. An instance of this is found in syphilis. The active immunity lasts during the infection, and while antibodies are probably present in the body permanently, the susceptibility toward the disease returns on the advent of complete cure. A third class of invading bacteria is met with, in which superinfection occurs, and no protection follows cure. The existence of a gonorrhœal infection probably does not prevent the indiyidual from becoming infected a second time. It is not impossible that superinfection with the tubercle bacillus may occur. It is evident that the prospects of cure by bacterial products or antibodies are greatest in the first class, and are less favourable in the third than in the second.

The production of immune bodies or antibodies in an individual who has not been infected will be free in the first class, and is unlikely to happen in the third. The introduction of serum containing these antibodies on theoretical grounds should lead to a passive immunity of a duration in inverse proportion to the susceptibility of the individual to the infection. Man is susceptible to enteric fever, and antibodies are formed readily and in large excess as a result of an attack. We would therefore expect that the duration of a passive immunity to this disease would be of short duration. As a matter of fact, passive immunity to enteric fever does not appear to be a practical proposition at all. The reason for this, however, is complicated by circumstances with which we cannot deal in this place. In diphtheria and in tetanus, the conditions for inducing a passive immunity are more favourable, but since the human race is highly susceptible to both infections and antibodies form readily during an infection, the passive immunity is of short duration. Drs. A. T. MacConkey and Annie Homer have made a special study of the length of the passive immunity to tetanus infection.[1] They found that guinea-pigs could be protected from the lethal effects of tetanus toxin by one antitoxic unit given seven days before the toxin. Smaller protective doses did not suffice. If man were as susceptible to tetanus toxin as the guinea-pig, the protective dose required weight-for-weight would be 250 United States of America units. A dose of 500 units would allow of a man being twice as susceptible as a guinea-pig. When the interval between protection and testing be prolonged to a fortnight, the immunity is found to have vanished to a great extent. The animal may survive the toxic dose, but symptoms become apparent. After three weeks no trace of protection remains. They show that even when enormous doses of antitoxin are administered a full degree of protection is rarely afforded after an interval of three or four weeks. The doses given were up to 9,000 units. The deduction drawn by Drs. MacConkey and Homer are that after a prophylactic dose of antitoxin is given, the patient should be watched for the first sign of tetanus, and on its appearance tetanus antitoxin should be given again liberally. Other observers are inclined to repeat the prophylactic injections without awaiting the onset of symptoms.

[1] *The Lancet*, February 17, 1917.

Naval and Military.

The 288th and the 289th lists of casualties, which were issued on April 20 and April 23, 1917, respectively, contain the names of 1,830 officers, men and nurses, including two of medical officers. It is with great regret that we note the name among those killed in action of Captain B. H. Mack, and of those wounded, that of Captain J. Sprent.

It has been reported that Captain Keith Barrett, of the Royal Fusiliers, son of Lieutenant-Colonel J. W. Barrett, of Melbourne, has died of wounds received on April 17, 1917.

Lieutenant-Colonel J. B. St. Vincent Welch was decorated with the Distinguished Service Order by His Majesty on February 17, 1917.

Captain John Hardie has been awarded the Military Cross.

The following announcement appears in the *Commonwealth of Australia Gazette*, No. 61, of April 19, 1917:—

> His Excellency the Governor-General, acting with the advice of the Federal Executive Council, has been pleased to approve of Captain (provisional) R. F. O'Sullivan being granted temporary rank of Major and pay consolidated, at the rate of £550 per annum, inclusive of all allowances except travelling, whilst holding the temporary appointment as Staff Officer to Director-General, Australian Army Medical Services. Dated 1st April, 1917.

Public Health.

THE HEALTH OF NEW SOUTH WALES.

The following notifications have been received by the Department of Public Health, New South Wales, during the fortnight ending April 14, 1917:—

	Metropolitan Combined District. Cs.	Dths.	Hunter River Combined District. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Enteric Fever ..	25	0	2	0	31	6	58	6
Scarlatina	69	1	3	0	55	0	127	1
Diphtheria	173	5	20	0	212	3	405	8
C'bro-Sp'l Menin.	3	1	0	0	15	4	18	5
Poliomyelitis ..	1	1	0	0	0	0	1	1
*Pul. Tuberculosis	69	24	0	1	0	0	69	25

* Notifiable only in the Metropolitan and Hunter River Districts, and, since October 2, 1916, in the Blue Mountain Shire and Katoomba Municipality.

THE HEALTH OF VICTORIA.

The following notifications have been received by the Department of Public Health, Victoria, during the week ending April 15, 1917:—

	Metropolitan. Cs.	Dths.	Rest of State. Cs.	Dths.	Total. Cs.	Dths.
Diphtheria	64	2	29	2	93	4
Scarlatina	25	0	10	0	35	0
Enteric Fever	9	0	12	0	21	0
Pulmonary Tuberculosis	35	5	8	2	43	7
C'bro-Spinal Meningitis	4	—	0	—	4	—

THE HEALTH OF QUEENSLAND.

The following notifications have been received by the Department of Public Health, Queensland, during the week ending April 14, 1917:—

Disease.	No. of Cases.
Diphtheria	41
Erysipelas	2
Pulmonary Tuberculosis	9
Scarlatina	24
Poliomyelitis	2
Enteric Fever	15
Cerebro-Spinal Meningitis	6

THE HEALTH OF SOUTH AUSTRALIA.

The following notifications have been received by the Central Board of Health, Adelaide, for the week ending April 7, 1917:—

	Adelaide. Cs.	Adelaide. Dths.	Rest of State. Cs.	Rest of State. Dths.	Totals. Cs.	Totals. Dths.
Diphtheria	1	1	13	1	14	2
Enteric Fever	1	1	7	0	8	1
Pertussis	0	0	7	0	7	0
Pulmonary Tuberculosis	3	1	3	2	6	3
Morbilli	1	0	1	0	2	0
Scarlatina	0	0	2	0	2	0
Erysipelas	0	0	1	0	1	0

THE HEALTH OF TASMANIA.

The following notifications have been received by the Department of Public Health, Tasmania, during the fortnight ending April 14, 1917:—

Disease.	Hobart. Cases.	Launceston. Cases.	Country. Cases.	Whole State. Cases.
Diphtheria	9	8	35	52
Enteric Fever	5	4	2	11
Pulmonary Tuberculosis	3	3	3	9
Scarlatina	0	0	2	2

INFECTIVE DISEASES.

Two Bulletins of the Quarantine Service, dated March 2 and 16, 1917, contain the following information:—

Plague.

During the period from December 24, 1916, to February 3, 1917, 92,255 cases of plague and 72,515 deaths were registered in India. The number of cases reported in Java since the issue of the last notice was 36, and of these 25 were fatal. There were 38 cases reported in Ceylon between January 1 and February 10, 1917. In Egypt seven cases and two deaths occurred between January 1 and February 1, 1917, and in the fortnight ending February 3, there were two cases and two deaths in Hongkong. In the period of three weeks ending January 28, 1917, four cases and four deaths were registered in South Africa. Four fatal cases occurred in the Straits Settlements between February 7 and March 11, 1917.

Cholera.

The records reveal that ten cases of cholera occurred in the Philippine Islands between January 14 and February 10, 1917, and four deaths. Three additional cases have been notified in the Dutch East Indies.

Variola.

A Bill of Health covering the period of one week ending February 12, 1917, issued in Hongkong, gives information of 44 cases of smallpox and 39 deaths. There were 29 cases reported in the United States of America during the fortnight ending February 12, 1917. From the Dutch East Indies reports of 29 additional cases and of 12 deaths have been received. There were 12 cases of varioloid during the four weeks ending February 10, 1917, in the Philippine Islands. Nine cases of variola have been notified in the Straits Settlements since January 1, 1917.

Typhus Fever.

The distribution of typhus fever between the dates of December 30, 1916, and February 2, 1917, is given in the Reports of the United States Public Health Service as follows:—

Place.	Cases.	Deaths.
Mexico	662	—
Egypt	530	280
Russia	192	47
Java	97	6
Austria-Hungary	12	1
Germany	9	10
China	8	—
Netherlands	6	—
Great Britain	4	—
Switzerland	1	—
Cuba	1	1
Tunisia	1	—
Sweden	1	—
Turkey-in-Asia	1	—
Greece	—	11
Spain	—	2
Belgium	—	2
Argentina	—	1

Quarantine Arrangements.

The appointment of the Port of Cooktown, Queensland, as a first port of entry for vessels arriving from the ports of New Guinea has been cancelled, as this port has ceased to be a Customs port.

Vital Statistics.

SOUTH AUSTRALIA.

The returns of the vital statistics of South Australia for the month of February, 1917, have been published in *The South Australian Gazette* of March 22, 1917.

The number of births registered during the month was 830. The estimated population was 439,660, and consequently the birth-rate, expressed as an annual rate, was 22.24 per 1,000 of population. This rate is the lowest for the month of February since 1912. The average rate during the preceding five years for the month was 26.14.

The number of deaths registered during the month was 318. This number is considerably lower than the number registered in February during the past six years. The death-rate is equivalent to an annual death-rate of 8.64. The average for February during the preceding five years was 9.68. There were 60 deaths of infants under 1 year of age. The infantile death-rate was therefore 72.29 per 1,000 births. There were 83 deaths of persons of 60 years and over and 31 of persons of 80 years and over.

In regard to the causes of death, it appears that in 44 cases the fatal issue was determined by some affection of the cardio-vascular system. There were 22 deaths from organic disease of the heart, 14 from cerebral hæmorrhage and two from acute endocarditis. Of the infective processes diarrhœa and enteritis was the cause of 29 deaths, tuberculosis was the cause of 24 deaths, pertussis was the cause of 13 deaths, pneumonia of 8 deaths, meningitis of 7 deaths, enteric fever of 6 deaths, bronchitis of 6 deaths, diphtheria of 3 deaths, acute nephritis of 2 deaths, and dysentery, non-puerperal septicæmia, acute rheumatism, and pleurisy were the causes of one death each. In addition there were two deaths due to puerperal septicæmia. The deaths from meningitis probably include some from epidemic cerebro-spinal meningitis. Cancer caused 27 deaths and Bright's disease caused 7.

The statistics for the city of Adelaide are published in two separate tables. The birth-rate for the month was equivalent to an annual rate of 28.44 per 1,000 of population. While the birth-rate for the whole State was considerably lower than the average for February, that for the city was distinctly higher. The death-rate, expressed as an annual rate, worked out at 19.08 per 1,000 of population. The infantile death-rate was 180.85. From the figures it appears that this very high rate was due to the prevalence of gastro-enteritis.

Abstracts from Current Medical Literature.

SURGERY.

(132) Cholecystostomy versus Cholecystectomy.

John B. Deaver (*Surg., Gynecol. and Obstet.*, March, 1917) discusses the relative merits of cholecystostomy and cholecystectomy in diseased conditions of the gall bladder and biliary passages. He states that he is unacquainted with any question in abdominal surgery more difficult to decide with finality, and on the basis of incontrovertible evidence, than this. Statistics are most fallacious at the present time, since shifting of opinions and changes in practice have made it impossible for any one to collect series which are strictly comparable. Formerly the mortality of cholecystectomy in the writer's hands were distinctly higher than that of cholecystostomy, but during the last year this condition has reversed itself. This does not prove anything as to the relative dangers of the two operations, but is explained by the fact that formerly he removed gall bladders which showed extensive disease and drained those that were but slightly involved, whilst latterly he has removed all gall bladders, whether the seat of mild or severe lesions, and has drained chiefly those that have presented contra-indications to removal in the shape of severe local lesions or general symptoms. One conclusion definitely arrived at is that the mortality difference in the two types of operation is much less than the mortality due to the local disease and the general condition of the patient. The real objective of the subject is not the relative merits of the two operations, but the failure of the profession to recognize the surgical nature of gall bladder disease and the delay which ensues therefrom before surgical treatment is undertaken. If only the notion that gall stones are the essential indications for surgery in cholecystic disease could be eradicated, it would be a great gain. The author believes that cholecystectomy in the average case will show a slightly higher mortality than cholecystostomy. This is accounted for by the increased trauma and the longer time taken to complete the operation. Cholecystostomy will not cure all cases, and the gall bladder must be removed in cases of hydrops or empyæma, or where the cystic duct is strictured or contains an impacted stone. The "strawberry" gall bladder must be removed to effect a complete cure. The only excuse for leaving behind a gangrenous or suppurating gall bladder is in case the dangers of immediate removal contra-indicates that step. A percentage of cases fail to obtain or maintain the expected result after operation upon the biliary tract. Since 1910 in one hospital there were 1,189 cases of this type. Fifty-one of these cases had one or more previous operations on the biliary passages, so that 4.2% of the work represented previous failure to cure. In 65% of the cases of recurrence after cholecystostomy the cause of recurrence was directly due to failure to remove the gall bladder. In 14 cases stones were present in the cystic duct or gall bladder. In two the cystic duct was strictured, and in six infection had relighted in the gall bladder. Some of the recurrences were due to stones which had been overlooked in the common or hepatic duct. In the cases of recurrence after cholecystectomy the group due to persistent infection comprised but one case of pancreatitis. This may have been due to a cause other than biliary disease. This brief analysis shows that from the standpoint of the end results infective conditions of the biliary tract are best treated by removal of the gall bladder. This agrees with the recent work of Rosenow on the persistence of bacteria within the wall of the gall bladder. The author believes that cholecystectomy in the presence of jaundice and in the absence of a macroscopically diseased gall bladder is out of place and cholecystostomy the operation of choice. Jaundice, in the absence of inflammation and obstruction of the common duct, is most probably due to cholangitis, and requires drainage. Adhesions are more frequent after cholecystectomy. In 1,800 operations on the bile passages no dilatation of the common duct, to which attention has been called by recent writers, has been met with. In the majority of cases met with cholecystectomy is performed, but where the infection is more distinctly cholangitic and intrahepatic, as evidenced by minor appearances of inflammation of the gall bladder with thickening, enlargement and streaky appearance of the liver, or when the major lesion is in the pancreas or common duct the gall bladder is allowed to remain and used for either internal drainage by cholecysto-duodenostomy or for prolonged external drainage by cholecystostomy.

(133) Appendix Dyspepsia.

An article by Clarence A. McWilliams on appendix dyspepsia appears in the *Medical Record* of February 24, 1917. The author states that there are many patients going to the general practitioner for treatment for "indigestion" of various kinds, particularly those with pyloro-spasm and hypersecretion, who obtain but temporary relief from any form of medical treatment, even though it be faithfully, persistently and intelligently prescribed and carried out. These patients often drift into the hands of a stomach specialist, who recognizes the futility of medical treatment, even though on objective examination nothing can be elicited over the gall bladder, stomach or appendix. The case is then sent to the surgeon, who, if he has confidence in the "gastro-enterologist," will be wise if he removes the appendix. It must not be forgotten that a fibroid involution of the appendix, when the organ is free from infection, may give rise to no tenderness or pain in the organ, provided no point of stricture is produced, with its resulting damming back of secretion. Nerve filaments are, however, imprisoned in a new connective tissue in the walls of the appendix, and from these, on account of the pinching, reflexes are sent out, in some instances producing an irritable condition of the pyloric sphincter, resulting in pyloro-spasm, with gastric hypersecretion and consequent digestive disturbances. Instances of these conditions are related, and the author expresses the opinion that they may be regarded as a warning not to use the terms, nervous indigestion, neurasthenia, intestinal toxæmias, gastralgia, etc., unless an organic basis has been excluded. Many cases of appendicular gastralgia are cured by removal of the appendix, but Patterson is quoted as making the assertion that in from 10% to 12% of the patients suffering from chronic reflex disturbances who are subjected to appendectomy, this operation is not followed by relief. This is explained by the fact that a superficial gastric ulcer may have been present at the time of the exploration, but not discovered on external examination.

(134) False Coxalgia, Arthritis and Osteomyelitis of the Hip.

M. Savariand deals with false coxalgia, arthritis and osteomyelitis of the hip (*Med. Press and Circular*, January 10, 1917). He points out that a peculiarity of ordinary coxalgia is that the insidiousness of its course makes it rarely possible to decide when the affection begins. In cases where a date can be assigned it is necessary to bear in mind the possibility of its being an acute arthritis, or even an osteomyelitis. Acute suppurating arthritis is common during the first year of life, runs a rapid course, and is accompanied by fever and severe pain. Small children should be completely undressed while under examination. The fixation and the swollen leg-of-mutton shape of the affected hip draw attention to the condition. The abscess points usually in the gluteal region, or at the anterior or inner aspect, over the adductors. The presence of these symptoms will exclude the idea of coxalgia. Symptomatic abscesses, from suppurating inguinal or iliac glands, provoke retraction of the psoas muscle, and to that extent simulate acute arthritis; but there is absence of pain on pressure in the gluteal region. The only real difficulty of diagnosis is that of osteomyelitis of the neck of the femur. Osteomyelitis is rare in young children, whose articular extremities are almost entirely cartilaginous. The author considers that the diagnosis is not a matter of great importance from the point of view of treatment, since in both instances the abscess must be freely opened. The prognosis *quoad vitam* is good, provided that no other joints are involved. The distant result is vari-

able. There may be complete restitution, or there may be dislocation and pseudarthroses. Ankylosis is exceptional, because the articular ends in young children are almost completely cartilaginous. Osteomyelitis of the hip may start from a lesion of the *os innominatum* at the site of the junction of its three segments. These cases are very grave, but are fortunately rare. The most frequent form met with is that of the neck of the femur. It is soon followed by detachment of the head of the femur. Mild cases of this type which do not suppurate may be mistaken for coxalgia. The author's treatment of these cases is given in full.

GYNÆCOLOGY AND OBSTETRICS.

(135) External Determination of Dilatation of Os in Labour.

Welz (*Americ. Journ. Obstet.*, February, 1917), after advocating the advisability of avoiding vaginal examinations during labour and minutely explaining the cause of Bandl's ring, or contraction ring, proceeds to describe Unterberger's method of determining the amount of dilatation of the external os during labour by means of abdominal palpation. Unterberger observed that as labour advances the contraction ring gradually rises from the pelvis, until it occupies a space midway between the *symphysis pubis* and umbilicus, when dilatation of the os is complete. The rise is proportional to the dilatation of the external os. When the ring cannot be felt above the symphysis, the dilatation has not reached the size of a dollar. When it has reached this degree (about 4 cm. diameter) the ring can be felt about two fingers' breadth above the symphysis. At three fingers' breadth above pubis the os is about 8 cm. diameter and at full dilatation it is four fingers' breadth above, and runs transversely across uterus. It is to be felt only during contractions, except in cases of threatened rupture, when it may also be felt between them. Unterberger tried this method in 300 cases, which were also examined internally, to determine the correctness of the method; of these, 285, or 95%, were correctly diagnosed. The fifteen failures were due to partially distended bladders obscuring the ring. In only three cases did the height of the ring not correspond to the amount of dilatation of the external os. The author recommends the method, and is collecting a series, using internal examinations to check the external findings. He considers that it requires a certain amount of patience to attain proficiency, and regards failure as due to distension of bladder or excessively fatty and extremely rigid abdominal walls. To him the ring feels as a furrow above the thinner lower segment, and it can best be felt by placing the finger tips lightly just above the symphysis and moving them slowly upwards until a furrow is felt transversely. It is easier to note in primiparæ than in multiparæ, and it is more distinct the higher it rises.

(136) Vaginal Delivery After Cæsarean Section.

Mason (*Boston Med. and Surg. Journ.*, January 25, 1917), after an exhaustive review of the subject, is of opinion that the scar of a Cæsarean section, when sutured by the improved technique of the present day, with a convalescence free from infection, will be strong enough to withstand the distension of a full-term pregnancy and the strain of labour. He admits that the majority of obstetricians consider that "once a Cæsarean always a Cæsarean" should be the axiom, basing their view on the theory that the scar in the uterus weakens the uterine wall at that point, and makes rupture of the uterus a grave danger in the event of subsequent pregnancy and labour. The object of the article is to point out that the patient who has had a Cæsarean section properly done for some cause other than a pelvic condition, may with safety, as far as the scar is concerned, be subjected to future pregnancy and vaginal delivery, provided her convalescence has been afebrile and free from uterine infection. He and J. T. Williams, by experiments on pregnant cats and guinea-pigs in 1910, showed that when weights were suspended from sections of the uterine wall containing linear scars, rupture invariably occurred in the adjoining muscle, and not in the scar itself. He quotes many authorities in support of the view that it is often preferable to allow labour to terminate naturally than to perform a second Cæsarean section. He has found that the longitudinal fundal incision and operation when contractions have started is more likely to give the best result from the standpoint of future strength of the scar. He also considers chromicized catgut and suturing by layer advisable from a similar point of view. He proceeds to quote in support of his view the case records of 31 cases without mishap to the scar, and he states in conclusion that a thorough search throughout the community to find cases of rupture of the scar of a previous Cæsarean section in subsequent pregnancy or labour revealed but one case.

(137) Incontinence of Urine.

H. C. Taylor and C. H. Watt (*Surg., Gynec. and Obstet.*, March, 1917) give their results of the study of acquired incontinence in women, based on one thousand cases in the Gynæcological Service of the Roosevelt Hospital. They are of opinion that incontinence of urine may be the result of lesions (1) inside the *sphincter vesicae*, (2) in the *sphincter vesicae* itself, and (3) outside the *sphincter vesicae*. The first is commonly in the form of an increased irritability of the bladder due to cystitis or trigonitis. The lesions in the second class may be (*a*) an actual destruction of sphincter muscle from injury or ulceration, (*b*) an overstretching of the sphincter by instrumentation, (*c*) a weakening of the muscle, as in advanced age and in prolonged serious illness, or (*d*) interference with the nerve supply, as in some cases of disease of central nervous system. Thirdly, outside the *sphincter vesicae*, incontinence of urine is caused by a displacement of the neck of the bladder and urethra usually associated with a prolapse of the anterior vaginal wall. They are of opinion that the prolapse of the neck of the bladder and posterior urethra does not involve the entire circumference of the urethra, but only the lower part, and that incontinence is caused by the prolapse or dragging of the under part of the neck of the bladder, which tends to hold the sphincter open and interferes with its proper action. They assert that this explanation of the pathology of incontinence in this class of cases is supported by the treatment for its cure. An operation or pessary to remove this drag on the sphincter is usually followed by success. Finally they give an account of the special treatment for each class of case, describing the most suitable operative measures for lesions causing incontinence in the *sphincter vesicae* itself, and for those outside the *sphincter vesicae*, and come to the following conclusions: (1) Incontinence of urine due to a lesion of the *sphincter vesicae* only is relatively an infrequent symptom. (2) Incontinence of urine due to a lesion of the *sphincter vesicae* associated with other lesions is a frequent and important condition. (3) In pelvic operations for lesions associated with incontinence of urine as a symptom, care should be used to remove all drag or downward traction on the anterior vaginal wall and frequently to infold the *sphincter vesicae*.

(130) Perineal Anæsthesia in Labour.

King (*Surg. Gynec. and Obstet.*, November, 1916) advocates the use of novocaine for the production of local perineal anæsthesia in labour. After describing in detail the anatomy of the fascial planes of the female perineum, and in particular Colles' fascia, which he regards as the most sensitive structure in the second stage of labour, he proceeds to outline his technique. The solution used is a 2% novocaine in normal saline with ⅛ of a minim of 1 in 1000 adrenalin chloride to each cubic centimetre. After sterilizing and spraying the perineal area with ethyl chloride, the needle is inserted in the anterior triangle 2 to 4 centimetres above lower margin of the vagina, and 2 centimetres from the ramus to a depth of 2 to 4 cm. corresponding to the level of the hymen or its remains, 1½ c.cm. of the 2% solution is injected. An injection of 5 to 10 c.cm. of a 1% solution is given in the posterior triangle midway between the anus and tuberosities to a depth of 4 cm. Injections are administered bilaterally; primiparæ require only the anterior injection. No adverse results follow the method. Anæsthesia begins in a few minutes, and it lasts for two to four hours. Lacerations are diminished in frequency, and the general practitioner can safely and easily apply the method at the bedside.

British Medical Association News.

SCIENTIFIC.

A meeting of the South Australian Branch was held at the House of the Branch, Hindmarsh Square, Adelaide, on February 22, 1917, Dr. J. C. Verco, the President, in the chair.

Dr. J. C. Verco showed specimens of *Nyssorhynchus annulipes* (*Anopheles maculipennis*) taken at the Torrens River, Adelaide, near the boatsheds. He called attention to the fact that this species of mosquito harbours the malarial parasite, and transmits it to the human subject. He stated that it had also been taken along the River Onkaparinga and at Overland Corner, on the River Murray. The importance of this habitat was in the fact that soldiers and civilians coming in vessels from malarial districts, *e.g.*, chaplains and crews of vessels, and having had malaria, were liable to infect these mosquitoes with the parasite and to establish malaria in the State and make it endemic. Speedy and efficient means should be taken to segregate all malarial invalids and suspects, and to prevent mosquitoes from sucking their blood until it has been proved to be free from the protozoon.

Dr. Verco also exhibited specimens of *Bulinus* and *Planorbis* from the Reedbeds, the River Onkaparinga and the River Murray. These were two *genera*, which were infested by the parasites, *Schistosomum haematobium*, generally known as *Bilharzia haematobia*. As the *myracidia* of the worm were sufficiently accommodating to infest species of two different *genera* in Egypt, Dr. Verco expected that they would probably accommodate themselves readily to different species of the same genus, and adopt as their hosts one or more species of each of the same genera represented in Australian waters, where they were very abundant.

In the third place, Dr. Verco demonstrated a skiagraph of both hands of a girl, aged 7 years. For about two years lumps had been growing on them without pain or discomfort. They were found to be somewhat elongate in the axis of the phalanges, oval in shape, not tender, quite hard and bony, not near the epiphysis. They varied from just perceptible elevations on the surface of the bone to well raised lumps somewhat larger than their base. They were at first supposed to be osteomata, but as numerous osteomata on the fingers and metacarpal bones of a child were outside his experience, he looked up the various surgical works, but could find nothing about them. A skiagraph, however, showed the growths to be not more opaque than the bones, as they should be were they osteomata. Indeed, they were less opaque. He therefore came to the conclusion that they must be soft, non-bony growths from the interior of the bone, expanding and thinning its bony covering. This suggested cartilaginous neoplasms. He had found reference to multiple chondroma on the hands of the young in surgical literature, with a good account of them in Paget's "Lectures on Surgical Pathology." The plate showed no fewer than nineteen distinct tumours, some of which were not to be recognized by palpation. They attacked the metacarpals and the proximal and middle phalanges. They did not spring from the epiphyseal cartilages, not from the periosteal surface, but from the medullary canal, and might enlarge this by pressure before they expanded the bone. A chondroma might occupy nearly the whole length of the cavity before it distended the bone at any point in its periphery; or it might grow as a spherical nodule at one spot in the cavity, and expand the bone on one side into a large bubble at this point, while the rest of the cavity and of the bone remained unaffected. The lower end of the right radius appeared from the skiagraph to be affected by the growth. In such a case were seen some years later, when the enchondromata, liberated from the pressure of the enclosing shell of bone, had grown into large, round, elastic tumours, no difficulty would be experienced in making an immediate and absolute diagnosis.

Dr. W. A. Verco read a paper on the value of drainage in some cases of Cæsarian section. The text of this paper will be found on page 353 in this issue.

MEDICO-POLITICAL.

A meeting of the Queensland Branch was held at the B.M.A. Rooms, Adelaide Street, Brisbane, on April 13, 1917, Dr. W. N. Robertson, the President, in the chair.

A letter from the Council of the New South Wales Branch, dated March 3, 1917, dealing with the subject of equality of obligation to serve in the Australian Army Medical Corps was read by the President. He announced that a copy of this letter had been sent to each member residing in Brisbane.

Dr. W. F. Taylor pointed out that the term "liable" was used in the letter. He would like to know the definition of this term, and also what was the age limit.

Lieutenant-Colonel A. M. McIntosh pointed out that the age limit for service with the Australian Imperial Force was 40 years, but that in exceptional cases men over 50 years of age had been enlisted.

Major G. A. C. Douglas said that under the proclamation men were to have been divided into two classes: (1) those under 45 years of age for active service, and (2) those between 45 and 60 years of age for home service.

Dr. E. S. Jackson moved a resolution similar to that adopted by the New South Wales Branch at its annual meeting (see *The Medical Journal of Australia*, April 7, 1917, p. 304).

Dr. J. L. Gibson seconded the motion, which was carried unanimously.

The President read a draft pronouncement which had been approved by the Council of the New South Wales Branch concerning the nationalization of the medical profession. This pronouncement would be submitted by the New South Wales members to the Federal Committee at its meeting on April 25, 1917.

Dr. G. L'Estrange said that there had been a Government medical service in Ireland for a number of years. It had worked very badly. All the best members of the profession had left the country.

Dr. W. W. Hoare moved, and Dr. E. S. Jackson seconded a motion to the effect that the Queensland Branch heartily endorced the principles contained in the pronouncement of the New South Wales Branch.

Captain E. Russell said that he thought that Dr. L'Estrange was confusing service under a local governing body with national service. The former was bad, but the latter had been a great success in England.

Dr. W. F. Taylor thought that national medical service had its advantages. It would be very good for young practitioners, but older practitioners with large practices would resent it. The officers of a national service would be pensioned in their old age, and would have regular holidays. He expressed the opinion that a national service might keep men from working as hard as they did, but he believed that they would always try to find out as much about disease as possible.

Dr. C. F. Marks said that he had advocated a scheme of national medical service many years ago. He had apparently been ahead of his time.

Dr. Wilton W. R. Love spoke in support of the motion.

The motion, on being put to the meeting, was carried *nemine contradicente*.

Dr. Herbert J. Stewart moved:—

> That with the consent of the meeting, the rule in relation to medical men attending Government institutions in an honorary capacity be waived, pending further information regarding the attitude of the Government in relation to the management of the Brisbane General Hospital, and that the present medical staff be allowed to continue their charitable work under the old regime until such occasion arises for further action to be taken.

Dr. C. A. Thelander seconded the motion.

After some discussion the motion was temporarily withdrawn.

Sir David Hardie moved:—

> That we approve of the following resolutions carried unanimously at the last Sydney Medical Congress and unamended at the Auckland Congress:
>
> 1. That in the opinion of this Congress no payment whatever should be taken from patients treated at hospitals maintained by the donation of the charitable and by Government grants;

2. If it be found necessary by the various Governments to undertake the entire financial support of the hospitals, this Congress affirms its strong belief that it is in the interests of the sick poor, as well as the general community, that patients whose circumstances enable them to obtain medical services outside the public hospitals should be excluded from these latter;

3. Unless such a provision is included in any Act to nationalize hospitals, the medical profession must reconsider its position with regard to its association with hospitals; and

4. The Congress also is strongly of opinion that it is in the best interests of the hospitals and their patients that Boards of Management should be retained in the event of any alteration of the present system of financial support.

Dr. W. F. Taylor seconded the motion. A discussion followed, in the course of which Drs. Gibson, Thelander and L'Estrange spoke in support of the motion, which was carried *nemine contradicente.*

Dr. J. C. Hemsley moved:—

That the Queensland Branch is strongly of opinion that all appointments to the honorary staff of any hospital should be made by the Committee on the recommendation of the Medical Board of the Hospital.

The motion was seconded by Dr. J. L. Gibson, and carried *nemine contradicente.*

The President read a letter from the Australian Natives' Association, informing the Council that at a Conference of the Australian Natives' Association of Queensland held recently it had been resolved unanimously to ask the Council of the Queensland Branch of the British Medical Association to receive a deputation, and requesting the Council to fix a date for receiving this deputation. The President asked the members to determine whether they were in favour of receiving a deputation, or not.

Dr. G. W. F. Paul moved:—

That as the attitude of the Queensland Branch of the British Medical Association to the Australian Natives' Association was unchanged, a further conference between these bodies would be futile.

Dr. E. S. Jackson seconded the motion, and Dr. W. F. Taylor supported it.

Dr. C. A. Thelander asked the members to be consistent. If the Branch refused to treat the Australian Natives' Association as a benefit society, it should treat the Hibernians and Protestant Alliance in the same manner, as these bodies were at present active political organizations.

The motion was put to the meeting, and was carried *nemine contradicente.*

On Dr. Paul's motion it was resolved that a copy of the resolution should be published in the public press.

Dr. J. L. Gibson referred to the fact that Captain John Hardie had been awarded the Military Cross.

Glen Howard Burnell, M.B., B.S. (Adelaide), of Kensington Gardens, South Australia, has been elected a member of the South Australian Branch.

Dr. Walter Terence Joseph Harris, of Pambula, New South Wales, has been nominated for election as a member of the New South Wales Branch.

THE MEDICAL BENEVOLENT FUND OF NEW SOUTH WALES.

The following is the Treasurer's account with the Medical Benevolent Fund of New South Wales for the year 1916:—

Dr.—1916.

	£	s.	d.
Balance brought forward from 31st March, 1916	117	13	7
Subscriptions from March, 1916, to March, 1917	26	7	6
	£144	1	1

Cr.—1916.

	£	s.	d.
Bank Fees	0	10	0
Exchange	0	8	6
Stamps and Printing	3	2	6
Balance as per Pass Book £143 2 7			
Less Cheque to Sir Herbert Maitland for cash paid out of his pocket 3 2 6			
	140	0	1
	£144	1	1

At deposit in Savings Bank of N.S.W., Barrack Street, as per Pass Book, plus interest to 30th June, 1916 .. £307 16 11

Balance at credit Current account, Commercial Banking Co. of Sydney, Bathurst Street Branch, as per Pass Book .. 140 0 1

Total credit at this date .. £447 17 0

Audited and found correct—H. L. MAITLAND. G. PATERSON.

VENEREAL DISEASES ACT IN TASMANIA.

The following is the text of the amendment of "The Public Health Act, 1903," dealing with the control of venereal diseases:—

An Act to Further Amend "The Public Health, Act, 1903," and for other purposes.

[23 February, 1917.]

Be it enacted by His Excellency the Governor of Tasmania, by and with the advice and consent of the Legislative Council and House of Assembly, in Parliament assembled, as follows:—

1. This Act may be cited as "The Public Health Act, 1917," and shall be incorporated with and construed as one with "The Public Health Act, 1903" (in this Act referred to as the "Principal Act"), and every amendment thereof.

2. The following Part is hereby inserted after Part II. of the Principal Act; that is to say:—

"PART IIa.

"VENEREAL DISEASES, AND DISORDERS AFFECTING THE GENERATIVE ORGANS.

"41*a*. (1) In this part of this Act, if not inconsistent with the context or subject-matter—

'Chief Health Officer' means the Chief Health Officer of Tasmania for the time being appointed under this Act, and includes an Acting Chief Health Officer:

'Child' means a person under the age of Sixteen years:

'Managers' includes board, committee, or other body managing any hospital:

'Part' means Part of this Act:

'Prescribed' means prescribed by this Part or by Regulations under this Part:

'Sheriff' means the Sheriff of Tasmania, and includes an Acting Sheriff:

'Venereal disease' means gonorrhœa, gonorrhœal ophthalmia, syphilis, soft chancre, venereal warts, or venereal granuloma.

"(2) Words importing the masculine gender shall be deemed and taken to include females.

"(3) Any reference to a medical practitioner shall, in any case where a person attends for treatment at a hospital, dispensary, or other prescribed place, and with respect to notices required by this Part in such a case, mean the medical officer of the hospital or other prescribed place for the time being in charge of cases of venereal disease thereat.

"41*b*. The Governor may, by proclamation, appoint any hospital maintained by or receiving aid from the State, or any ward of any such hospital, as a place in which persons may under this Part be detained for treatment.

"41*c*. (1) No person, other than a medical practitioner or a person acting under the direct instructions of a medical practitioner, shall attend upon or prescribe for, or supply any drug to, any person suffering from any venereal dis-

ease for the purpose of curing, alleviating, or treating such disease.

"Penalty: Fifty Pounds or Six months' imprisonment.

"(2) This section shall not apply to a registered pharmaceutical chemist who dispenses to the patient of a medical practitioner the prescription of such practitioner: Provided such prescription is—

(*a*) Dated;

(*b*) Bears the address and usual signature (including the surname) of such practitioner.

"41*d*. Every person suffering from any venereal disease, or suspecting that he is so suffering, shall, forthwith on his becoming aware of his condition, consult a medical practioner thereon, and for the purpose of examination and treatment that may be necessary place himself under such medical practitioner, or shall attend at some hospital or other place prescribed for the purpose and place himself under treatment thereat as may be deemed necessary.

"Penalty: Twenty Pounds.

"41*e*. (1) Every person suffering from any venereal disease who has consulted and placed himself under treatment by a medical practitioner, or has attended or placed himself under treatment at a hospital or other prescribed place, shall (until he has received a certificate of cure or of being free from venereal disease) personally attend or cause himself to be attended by a medical practitioner, or personally attend at a hospital or other prescribed place for the purpose of treatment and advice, at least once in every such period, not exceeding four weeks, as is prescribed, and shall follow the advice given by such medical practitioner or by a medical practitioner at such hospital or place.

"Penalty: Twenty Pounds.

"(2) If any such person, by reason of change of residence or otherwise, desires to change his medical adviser, or if the medical practitioner attending such person dies or for any reason is unable or unwilling to attend him further, such person shall forthwith consult and place himself under the treatment of another medical practitioner, and inform his new adviser of the name and last known address of his last previous adviser. The medical practitioner so informed shall forthwith send a notice in the prescribed form of the change made by the patient to such previous adviser, if such adviser is living and in Tasmania.

"Penalty: Five Pounds.

"41*f*. If a medical practitioner becomes aware that any person consulting or attended or treated by him is suffering from any venereal disease, the medical practitioner shall, in the prescribed form and within the prescribed time, give notice thereof to the Chief Health Officer.

"Such notice shall not disclose the name and address of the patient.

"Penalty: For a first offence, Twenty Pounds; and for a second and every subsequent offence, One hundred Pounds.

"41*g*. (1) If any patient who has been attended or treated by a medical practitioner for any venereal disease fails to consult or attend such medical practitioner for a period of six weeks, and the medical practitioner has not within that period received from another medical practitioner a notice that the patient has changed his medical adviser, such first-mentioned medical practitioner shall send to the Chief Health Officer in the prescribed form a notice of the facts, including the name and address of the patient.

"(2) Any medical practitioner whose duty it is to do so who does not send the said notice to the Chief Health Officer shall be liable for a first offence to a penalty of not more than Twenty Pounds, and for a second or any subsequent offence to a penalty of not less than Twenty Pounds or more than One hundred Pounds.

"41*h*. Every medical practitioner who attends or advises any patient for or in respect of any venereal disease from which the patient is suffering shall—

(1) By written notice in the prescribed form delivered to the patient—

(*a*) Direct such patient's attention to the infectious character of the disease and to the legal consequences of infecting others; and

(*b*) Warn the patient against contracting any marriage until certified as cured: and

(2) Give such patient such printed information relating to the disease and the duties of patients as is prescribed.

"Penalty: Five Pounds.

"41*i*. Subject to this Part, when any patient as aforesaid becomes cured of or free from venereal disease, or has ceased to be liable to convey infection, any medical practitioner shall, on being satisfied of the fact, give such patient a certificate in the prescribed form that such patient is cured or is free from venereal disease, or is no longer liable to convey infection (as the case may be).

"41*j*. (1) Any parent, guardian, or other person in charge of any child suffering from any venereal disease shall cause such child to be treated by a medical practitioner.

"Penalty: Ten Pounds.

"(2) When any child is or becomes liable under this Part to do or submit to any act, matter, or thing, any parent or guardian or other person in charge of such child who knows that such child is so liable, shall exercise his authority to compel or induce such child to do or submit to such act, matter, or thing as aforesaid.

"Penalty: Ten Pounds.

"(3) Any parent or guardian or other person in charge of any such child who knows that such child has failed to comply with any provisions of this Part applicable to such child, shall report the fact, together with such particulars as are prescribed, to the Chief Health Officer.

"Penalty: Ten Pounds.

"41*k*. (1) Whenever the Chief Health Officer is satisfied—

I. By the certificate of a medical practitioner; or

II. By a signed statement in which shall be set forth the full name and address of the informant—

that any person is suffering from venereal disease, and is not under treatment by any medical practitioner, he may issue an order in writing requiring such person to place himself forthwith under the care of a medical practitioner.

"(2) If such person does not place himself under the care of a medical practitioner, a police magistrate, on the complaint of the Chief Health Officer or of a medical practitioner authorized in writing either generally or in any particular case for the purpose by the Chief Health Officer, may, by warrant under his hand in the prescribed form and directed to prescribed persons, order the person to be apprehended and to be detained for any prescribed period, not exceeding four weeks, in any prescribed place for any clinical, chemical, bacteriological, or other examination or investigation necessary to ascertain whether such person is suffering from venereal disease, and it shall be lawful to make any such examination or investigation; and such warrant shall be a sufficient authority to all persons for the arrest and detention of such person in pursuance of the warrant aforesaid and subject to the provisions of this Part any person proved guilty of furnishing a wilfully false signed statement under this section shall be subject to a penalty of Fifty Pounds.

"(3) If the result of any such examination or investigation discloses that such person is suffering from any venereal disease, and the Chief Health Officer after due inquiry into all the circumstances is of the opinion that further detention is necessary in the interests of such person and of the public welfare, and so reports to the Minister, then, on the recommendation of the Minister, the Governor may from time to time order that such person shall be detained under such conditions and in a prescribed or proclaimed place and for such time and be subject to such examination and treatment as are necessary to ensure that such person is cured or is free from venereal disease or has ceased to be liable to convey infection; and the Governor may extend or vary any such order or at any time terminate its operation, and thereafter, if found necessary, renew such order. And every such order shall be sufficient authority to all persons for the arrest and the removal or detention of such person in pursuance of the order until his release under the provisions of this section and subject to the provisions of this Part.

"(4) Any person undergoing detention under this section may from time to time apply in writing in the prescribed form to a judge of the Supreme Court or a police magistrate to be examined by two medical practitioners, and thereupon such judge or magistrate shall by order direct

any two or more medical practitioners named in the order (one of whom shall be nominated by the patient or some person on his behalf) to examine such person accordingly, and report the result of the examination to the judge or magistrate; and every officer or person in whose custody the person is shall permit the examination.

"If it appears from such report that all such medical practitioners are of opinion that the person is cured or is free from venereal disease, or has ceased to be liable to convey infection, the judge or magistrate shall order the release of such person from detention, and he shall be released accordingly.

"No such application shall be made by any person so detained within three months after a like prior application has been made by such person.

"(5) Any person undergoing detention under this section who proves to the satisfaction of the Minister that he can obtain, and is prepared to undergo, suitable private treatment may be released on the order of the Minister, subject to such conditions as the Minister imposes.

"(6) Any person undergoing detention under this section shall, once at least in every period of three months, beginning with the date of his arrest, be examined by two medical practitioners appointed by the Minister either generally or in any particular case for the purpose, in order to ascertain whether such person is cured or is free from venereal disease, or has ceased to be liable to convey infection, and such medical practitioners shall report to the Minister accordingly.

"If the Minister is satisfied that such person is cured or is free from venereal disease, or has ceased to be liable to convey infection, the Minister shall order the release of such person from detention, and he shall be released accordingly.

"Where the person undergoing detention has been examined by order of a judge or police magistrate under this section, an examination under this subsection shall not be necessary until a period of three months has elapsed after the firstmentioned examination.

"(7) No person shall be detained under this section after he is cured or is free from venereal disease or has ceased to be liable to convey infection.

"(8) No certificate of any medical practitioner given for the purposes of this or the next succeeding section *bonâ fide* and without negligence that any person (including any child or any prisoner) is suffering from venereal disease shall be admissible in evidence in any proceedings, civil or criminal, against such medical practitioner, or be made the ground of any prosecution, action, or suit against him.

"(9) Any person who—

I. Detains any person undergoing detention under this section, except as provided under this Part: or

II. Obstructs the carrying into effect of any warrant or order under this section: or

III. Refuses to do or submit to anything which such person is by this section, or any such warrant or order, required to do or submit to; or

IV. While undergoing detention under this section leaves, except as prescribed, any prescribed or proclaimed place before being lawfully discharged—

shall be guilty of an offence against this Act.

"Penalty: Twenty Pounds.

"41*l*. (1) Where a medical practitioner duly appointed, either generally or in any particular case for the purpose certifies in writing to the Minister that any prisoner in any gaol is suffering from any venereal disease, such prisoner may be brought before a police magistrate in the gaol, and on proof that such prisoner is so suffering, the police magistrate may order that such prisoner be detained under such conditions and in a prescribed or proclaimed place and for such time and be subject to such examination and treatment as are necessary to ensure that he is cured or is free from venereal disease or is no longer liable to convey infection.

"(2) Such an order shall be sufficient authority to the Sheriff to remove such prisoner to the prescribed or proclaimed place named in the order, and for his detention therein in pursuance of the order and subject to the provisions of this section.

"(3) During any period of detention under this section such prisoner shall be deemed to be in legal custody, and the period of detention shall run concurrently with, but may exceed, the term of imprisonment to which such prisoner has been sentenced.

"(4) The provisions of Subsection (4) of the last preceding section shall extend and apply to prisoners undergoing detention under this section.

"(5) If the Chief Health Officer is satisfied that any prisoner undergoing detention under this section is cured or is free from venereal disease, or is no longer liable to convey infection, he shall so report to the Minister, and thereupon the Minister shall order that such prisoner be discharged from such detention, and such prisoner, unless his sentence has sooner expired, shall be remitted to his former custody to serve the remainder of his sentence.

"(6) Notwithstanding anything in any Act or in any law to the contrary, it shall be lawful for any medical practitioner or practitioners duly appointed by the Minister, either generally or in any particular case for the purpose to examine any prisoner in any gaol for the purpose of ascertaining whether such prisoner is suffering from venereal disease, and to make such clinical, chemical, bacteriological, and other examinations and investigations as are necessary or expedient for the purpose.

"(7) The provisions of this section with respect to prisoners shall extend and apply to persons committed to and detained in industrial and training schools, and shall, with such alterations, modifications, and substitutions as are necessary, be read and construed accordingly: Provided that for the purposes of this subsection—

I. Upon the discharge of any such person from detention under this section such person shall be returned to the industrial school or training school from which he was removed: and

II. Any reference in this section to the Sheriff shall be read and construed as a reference to the person in charge of a training school or industrial school or the superintendent or matron of any such school (as the case may be).

"41*m*. (1) Any matter to be heard by a judge or police magistrate under any section of or regulation under this Part shall be heard and decided in chambers and in private, and no person other than the judge, or magistrate, the party concerned, the Chief Health Officer, and such officers, witnesses, or persons as the judge or magistrate may require or may, at the request of the party concerned, permit to be present, shall have access to or be permitted to be present in any room where the matter is being heard.

"(2) Every person who acts or assists in the administration of any such section or regulation, and every person present in any room where any matter under any such section or regulation is being heard, shall preserve and aid in preserving secrecy with regard to all matters and things which come to his knowledge while so acting or assisting or present, and shall not communicate any such matter or thing to any other person, except in the performance of his duties under this Part or in answer to some question which he is legally bound to answer.

"Penalty: Fifty pounds.

"41*n*. If any person to be examined under this Part is a female, then, if so desired by the person to be examined, the examination, if by one medical practitioner, shall if practicable be made by a medical practitioner who is a woman, and if by more than one medical practitioner all of such medical practitioners shall if practicable be women.

"41*o*. The fact that a person who has been suffering from any venereal disease has ceased to be liable to convey infection, but has not been cured, shall not exonerate such person from complying with the provisions of this Part with respect to treatment or any medical practitioner from complying with the requirements of this Part with respect to notices.

"41*p*. No person shall knowingly infect any other person with a venereal disease, or knowingly do or permit or suffer any act likely to lead to the infection of any other person with such a disease.

"Penalty: Imprisonment for Twelve months.

"41*q*. (1) The managers of any hospital receiving aid from the State shall make effective provision as prescribed for the reception, accommodation, examination, and treatment, free of charge, of such numbers of persons or such classes

of persons suffering from venereal disease as are prescribed.

"(2) In case of default the Treasurer of the State may withhold the whole or any portion of any subsidy which would be payable from the Consolidated Revenue in respect of such hospital during the current or the next financial year.

"41*r*. The Minister may—

I. Establish hospitals, dispensaries or places for the reception and treatment of persons suffering from venereal disease:

II. Arrange for the treatment by medical practitioners or at hospitals not receiving aid from the State, of persons suffering from venereal disease:

III. Arrange for clinical, chemical, bacteriological, and other examinations and investigations, free of charge, for the purpose of ascertaining whether a person is suffering from or is cured of any venereal disease, or whether he has ceased to be liable to convey infection: and

IV. Provide for the preparation and distribution of information relating to venereal diseases.

"41*s*. (1) The Governor may make regulations for or with respect to—

I. The forms and particulars to be contained in notices, returns, certificates, orders, and warrants under this Part:

II. The persons or classes of persons who may apprehend any person against whom a warrant or order of apprehension under this Part has been issued:

III. The conditions under which a certificate of cure of, or of freedom from, venereal disease, or of having ceased to be liable to convey infection, may be issued:

IV. The number of persons or the classes of persons who shall be eligible to receive free treatment for venereal diseases at a hospital maintained by or receiving aid from the State:

V. The management of any hospital, dispensary, or place provided by the Minister for the reception, accommodation, examination, or treatment of persons pursuant to this Part:

VI. Prescribing what medical officers of hospitals or other prescribed places shall have charge of cases of venereal disease treated thereat, and to or by whom notices required by this Part shall be given:

VII. The remuneration of medical practitioners for the free examination or free treatment of persons pursuant to this Part:—

VIII. The fees payable for clinical, chemical, bacteriological, and other examinations and investigations pursuant to this Part:

IX. Hospitals or places where persons suffering from any venereal disease may be detained for treatment:

X. Returns to be made by medical practitioners with respect to the number of cases of venereal disease attended or treated by them and the number of such cases cured:

XI. Prescribing the preventive measures against the spread of infection to be adopted by persons suffering from any venereal disease, and by persons attending or having the care or charge of such persons:

XII. Penalties, not exceeding Twenty Pounds, for any breach of any regulation made under this Part: and

XIII. Generally all matters the Governor deems necessary or convenient to be prescribed for carrying out the provisions of this Part.

"41*t*. All proceedings for offences against any of the provisions of this Part, or the regulations thereunder, and all penalties imposed under this Part, or the regulations thereunder, may be heard, determined, recovered, and enforced by and before a police magistrate, or any two or more justices in the mode prescribed by 'The Magistrates Summary Procedure Act.'"

Special Correspondence.

(By Our Special Correspondent.)

LONDON LETTER.

State Control of the Liquor Trade in Scotland.

By a majority, a representative conference held in Glasgow on November 17, 1916, adopted a resolution to the effect that, while many present would have preferred a measure of prohibition, the conference resolved that the State should acquire complete control of the sale of intoxicants in Scotland by purchasing on equitable terms the interests at present held by private traders, with the recommendation that the Scottish Temperance Act be brought into immediate operation. Lord Balfour of Burleigh, who presided over the conference, said that when they had eliminated private interest they would have made a great step towards the goal aimed at by prohibitionists, because they would have got rid of the feeling that they were interfering with the livelihood of those interested in the sale of liquor. State purchase was not put forward as a rival to other reforms, but as one way to make the path to reform easier than it was at the present time. Up to that time they had been unable to eliminate bad houses without increasing the value of those that remained. If they tried to stop off-sales at present they found the same result. They merely enhanced the value of other houses, which they might ultimately have to purchase. On these grounds he implored people with other ideas not to bar the path, because on a broad view the interests they all had at heart were not very divergent. If they stopped private interest all the political and social influence which went with it would disappear. Licensed premises could be reduced in number. There would be no such temptation to put them up at street corners and in all prominent places, as there was now. Hours would be shortened, and there would be no necessity for compensation or time-limit or any other matters of that kind. On the most liberal estimate it was calculated that the capital cost of the value of the retail trade in intoxicating liquors in Scotland was hardly more than the cost of one day of this war.

It is very doubtful whether this finding at all adequately represents the opinions of the majority of Scotchmen. Government control in other industries has not shown such conspicuous success as to make it likely that either the interests of the trade itself or the sobriety of the nation would be adequately benefited by such interference with private interests and personal freedom.

The Presidential Address at the General Medical Council.

Sir Donald MacAlister, President of the General Medical Council, made some important statements in his opening address of the winter session on November 28, 1916.

The Penal Cases Committee, he said, would not hesitate to advise a judicial investigation by the Council in any case where it was credibly alleged that a practitioner's certificates or notification were "untrue, misleading or improper."

The trust imposed in doctors in the granting of certificates of fitness or unfitness to persons under their care had been faithfully justified. Nevertheless, some had relaxed their usual vigilance, and from several important Government Departments communications had been received making it clear that in some parts of the country an impression of this nature existed among public authorities.

The Council had informed the Government Departments concerned that any charges would be dealt with under a full sense of gravity, and they awaited further action. They urged practitioners, meanwhile, to treat the certificates they issued as declarations made on honour and conscience.

The call for fresh supplies of trained and qualified medical practitioners to meet the needs of the ever-growing forces was more insistent now than ever.

He hoped that the few who had declined to take part in local schemes of co-operation would speedily reconsider their position and all that it involved.

If the voluntary organization of the profession should, by reason of their defection, fail to meet all the requirements of the medical service, legislative compulsion might

be needed for districts that were backward in their response to the calls of patriotism.

It might even be that increased disciplinary powers might be conferred on the Council to deal with individual cases of unfaithfulness to the special duty imposed upon practitioners by the national emergency.

Medical Research for Women.

In the annual report of the National Health Insurance Medical Research Committee for 1915-16 it is stated that an important feature of the year's work has been the increasing number of women engaged in pathological laboratories. To meet the depletion of pathological staffs at home, caused by the claims of the Services, the Committee have given encouragement and assistance, as far as lay in their power, to the rapid training of women as pathological assistants. Many women with a previous scientific education in other branches of biology have been able to fit themselves in a short time to give most efficient service in this way. In addition to those to whom the Committee have been able to give advice or facilities with a view to training of this kind, the Committee have provided grants in the past year for the whole- or part-time scientific employment on their behalf of more than twenty women, of whom, while some are giving only skilled routine assistance, others are engaged in definite research work. Among the original schemes for research framed by the Committee before the war only three women were taking a part.

Correspondence.

CYSTIC URETERS.

Sir,—With regard to the case published in your *Journal* on April 7 by Dr. Harris and Professor Welsh, in which they describe a condition of multiple cysts of the ureter, and about which they stated they had not come across any previous records, I would like to call your attention to the fact that Dr. A. H. Tebbutt studied a similar case in the post-mortem room at the Royal Prince Alfred Hospital in the early part of 1914. He regarded the condition as *ureteritis cystica*, a short reference to which occurs in Kelly and Burnam's "Diseases of the Kidneys, Ureters and Bladder." It was his intention to publish the case fully when the war broke out and prevented it. I have no doubt that he will publish the case later on when he has an opportunity. I may say that I had a look at Dr. Tebbutt's slides of the case, and they appear to me to be identical with the condition described by Dr. Harris and Professor Welsh.

Yours, etc.,

W. F. LITCHFIELD.

Sydney, April 22, 1917.

COMPULSORY ENROLMENT.

Sir,—I am sorry you cannot insert my letter and give the unpopular minority a say. The other side has occupied a good deal of the *Journal's* space in speeches. This subject is a very large one, and in my letter there are three matters, fairly broad, although connected with one another. A letter is the only way I have of expressing myself, badly I know, as I am no speaker; and in a matter like this and from the side I am speaking, one has to weigh one's words, which can be better done through writing than speech. It is difficult to shorten the letter without mutilating it. The *Journal*, by refusing to insert this note, lays itself open to the charge of trying to suppress the other side; to counteract which it should even, if necessary, go out of its way to give even a little more licence than its own side. It looks like an endeavour again to suppress freedom of expression and fear of the other side's case being heard. It bears out my remarks on intolerance.

Yours, etc.,

G. S. THOMPSON.

April 19, 1917.

[Dr. Thompson submitted to us a letter for publication which would have occupied over a page of small print. As it was impossible to place anything like this space at the disposal of one correspondent, we suggested to him that he should express his views in a letter of approximately 300 words. We were not influenced in refusing to publish the original letter by its contents, and cannot admit any disinclination to give "the other side" a fair hearing. Dr. Thompson can obtain the hearing he desires if he will limit his communication to a reasonable length. There has been in recent times a tendency on the part of several contributors to expand themselves unnecessarily in their letters for publication. We would suggest that a normal letter should not exceed 300 words, and that only under exceptional circumstances should correspondents claim a whole column.]

VISION OF PILOTS, ETC.

Sir,—Whilst the safety of the public (and of the seamen themselves) demands good vision and accurate perception of colour, the tests used should be guided by common sense and made under ordinary working conditions. In other words, it is unreasonable to make them with the pupils dilated by atropine or homatropine. This practice of artificial dilation is adopted by some examiners in Melbourne, and gives rise to much dissatisfaction, and leads to the turning down of men otherwise fit. A case in point will better show my meaning. A young man had been at sea for some years. He had passed the eyesight test for the R.N.R. and also the sight test when he obtained his first mate's certificate, and a third time when he obtained his master's certificate. Wishing to stay in Australia he applied to one of the largest offices. His credentials being in order he was sent on to the firm's oculist, a well-known Melbourne specialist. The pupils were dilated with homatropine, and under its influence a small amount of hypermetropia was found. The eye man turned him down for this. This is by no means an isolated case. A man who is examined under ordinary working conditions accepts the result without demur if he fails to pass the tests provided. The other way he regards as unfair, and naturally discontent arises, and many good men are lost to the service. It is absolutely irrational to examine under artificial abnormal conditions. Later this man was accepted by one of the biggest companies in England, passing their medical officer's examination, which was most stringent, but under normal conditions. Later he passed the Naval examination, and is doing good service as an officer on active service.

Yours, etc.,

LEONARD W. BICKLE, F.R.C.S. (Ed.).

Sydney, April 22, 1917.

Proceedings of the Australasian Medical Boards

NEW SOUTH WALES.

The following have been registered under the provisions of "The Medical Act, 1912 and 1915," as duly qualified medical practitioners:—

Robertson, William Lincoln, M.B., B.S., 1913, Univ., Melbourne.

Ward, Harold Whitfield, M.B., B.S., 1914, Univ., Melbourne.

O'Flynn, Jerome, M.B., Ch.B., 1913, N.U., Ireland.

Additional Registration.

Wiburd, Carvosso Roy, Ch.M., 1917, Univ., Sydney.

QUEENSLAND.

The following have been registered under the provisions of the "Medical Act of 1867" as duly qualified medical practitioners:—

Brown, Robert Graham, Brisbane, M.R.C.S., Eng., L.R.C.P., Lond., 1912.

Maye, John, Beenleigh, M.R.C.S., Eng., L.S.A., Lond., 1882.

Ross, James MacBain, Mount Morgan, M.R.C.S., Eng., L.R.C.P., Lond., 1901.

Additional Registration.

Luddy, John Joseph, Mount Morgan, Ch.M., Univ. Syd., 1912.

Books Received.

CLINICAL BACTERIOLOGY AND HÆMATOLOGY FOR PRACTITIONERS, by W. D'Este Emery, M.D., B.Sc.; 1917. London: H. K. Lewis and Company, Limited. Fifth Edition, Demy 8vo., pp. 310, with 11 plates and 55 illustrations. Price, 9s.

THE ORGANS OF INTERNAL SECRETION, THEIR DISEASES AND THERAPEUTIC APPLICATION, a Book for General Practitioners, by Ivo Geikie Cobb, M.D., M.R.C.S; 1917. London: Baillière, Tindall and Cox. Crown 8vo., pp. 228. Price, 5s.

Medical Appointments.

Dr. Arthur August Crooks, of Melbourne, has been appointed Government Medical Officer at Balranald, Victoria, in place of Dr. G. W. Foster.

His Excellency the Governor of New South Wales has been pleased to approve of the appointment of the Honourable John Brady Nash, M.D., M.L.C., as a Member of the Board of Directors of the Royal Prince Alfred Hospital, in place of the Honourable Sir Charles K. Mackellar, K.C.M.G., M.B., M.L.C., who has resigned.

Dr. Arthur Bridges Webb has been appointed Officer of Health to the Shire of Broadford, Victoria.

Dr. Walter William Stockton Jones has resigned his position as Officer of Health to the Shire of Phillip Island and Woolamai, Phillip Island Riding, Victoria, his successor being Dr. Albert William Graham.

Dr. Edward Joseph Savage has been appointed Government Medical Officer at Ayr, Queensland, in place of Dr. Frederick Samuel Thomas.

Dr. John Macarthur has been appointed Acting Medical Superintendent of the Dunwich Benevolent Asylum and Acting Superintendent of the Inebriate Institution at Dunwich, Queensland.

Medical Appointments Vacant, etc.

For announcements of medical appointments vacant, assistants, locum tenentes sought, etc., see "Advertiser," page xvii.

Brisbane Hospital, Junior Resident Medical Officers.

South Sydney Hospital, Honorary Bacteriologist.

Royal North Shore Hospital, Temporary Honorary Assistant Physician, Assistant Surgeon and Anæsthetist.

Medical Appointments.

IMPORTANT NOTICE.

Medical practitioners are requested not to apply for any appointment referred to in the following table, without having first communicated with the Honorary Secretary of the Branch named in the first column, or with the Medical Secretary of the British Medical Association, 429 Strand, London, W.C.

Branch.	APPOINTMENTS.
TASMANIA. (Hon. Sec., Bellerive, Tasmania.)	Honorary Medical Officers in all State-aided Hospitals in Tasmania.
VICTORIA. (Hon. Sec., Medical Society Hall, East Melbourne.)	Brunswick Medical Institute. Bendigo Medical Institute. Prahran United F.S. Dispensary. Australian Prudential Association Proprietary, Limited. National Provident Association. Life Insurance Company of Australia, Limited. Mutual National Provident Club.
QUEENSLAND. (Hon. Sec., B.M.A. Building, Adelaide Street, Brisbane.)	Brisbane United Friendly Society Institute.
SOUTH AUSTRALIA. (Hon. Sec., 3 North Terrace, Adelaide.)	The F.S. Medical Assoc., Incorp., Adelaide.
WESTERN AUSTRALIA. (Hon. Sec., 230 St George's Terrace, Perth.)	Swan District Medical Officer. All Contract Practice Appointments in Western Australia.
NEW SOUTH WALES. (Hon. Sec., 30-34 Elizabeth Street, Sydney.)	Department of Public Instruction—Appointments as Salaried Medical Officers, with duties which include the treatment of school children. Australian Natives' Association. Balmain United F.S. Dispensary. Canterbury United F.S. Dispensary. Leichhardt and Petersham Dispensary. M.U. Oddfellows' Med. Inst., Elizabeth Street, Sydney. Marrickville United F.S. Dispensary. N.S.W. Ambulance Association and Transport Brigade. North Sydney United F.S. People's Prudential Benefit Society. Phœnix Mutual Provident Society. F.S. Lodges at Casino. F.S. Lodges at Lithgow. F.S. Lodges at Orange. F.S. Lodges at Parramatta, Penrith, Auburn and Lidcombe. Newcastle Collieries — Killingworth, Seaham Nos. 1 and 2, West Wallsend.
NEW ZEALAND: WELLINGTON DIVISION. (Hon. Sec., Wellington.)	Friendly Society Lodges, Wellington, N.Z.

Diary for the Month.

May 2.—Vic. Branch, B.M.A., Branch.
May 4.—Q. Branch, B.M.A., Branch.
May 8.—Tas. Branch, B.M.A., Council and Branch.
May 8.—N.S.W. Branch, B.M.A., Ethics Committee.
May 10.—Vic. Branch, B.M.A., Council.
May 11.—N.S.W. Branch, B.M.A., Clinical.
May 12.—S. Aust. Branch, B.M.A., Council.
May 15.—N.S.W. Branch, B.M.A., Executive and Finance Committee.
May 16.—W. Aust. Branch, B.M.A., General.
May 16.—Western Suburbs Med. Assoc. (N.S.W.).
May 18.—Q. Branch, B.M.A., Council.
May 25.—S. Aust. Branch, B.M.A., Branch.
May 25.—N.S.W. Branch, B.M.A., Branch (Ordinary).

EDITORIAL NOTICES.

Manuscripts forwarded to the office of this Journal cannot under any circumstances be returned.

Original articles forwarded for publication are understood to be offered to *The Medical Journal of Australia* alone, unless the contrary be stated.

All communications should be addressed to "The Editor," *The Medical Journal of Australia*, B.M.A. Building, 30-34 Elizabeth Street, Sydney, New South Wales.